DOCUMENT RESUME

ED 435 320 HE 032 539

TITLE	A Model for Differentiated Nursing Practice.
INSTITUTION	National Organization for Associate Degree Nursing, Reston, VA.; American Association of Colleges of Nursing, Washington, DC.; American Organization of Nurse Executives, Chicago, IL.
PUB DATE	1995-00-00
NOTE	91p.; For a related document on nursing practice, see HE 032 540.
PUB TYPE	Guides - Non-Classroom (055) -- Opinion Papers (120)
EDRS PRICE	MF01/PC04 Plus Postage.
DESCRIPTORS	Allied Health Occupations Education; Change Strategies; *Education Work Relationship; Educational Change; Higher Education; Job Skills; *Labor Force Development; Labor Needs; *Labor Standards; *Nursing Education

ABSTRACT

This report describes the work of a task force of the American Association of Colleges of Nursing and the American Organization of Nurse Executives that was organized to delineate the competencies needed to provide for effective and efficient use of all workforce personnel and for more efficient use of the variety of programs that prepare nursing personnel. The resulting plan provides for rational workforce planning based on a differentiated set of nursing personnel and differentiated practice expectations for a changing health care environment. A number of conclusions and recommendations are reported, including: development of five to ten models of differentiated education/practice demonstration projects across the country; development of a core of leaders for differentiated education/practice projects; continued development of value-neutral language to describe differentiated nursing practice and education; and a plan for disseminating information about the initiative. The bulk of the document is contained in eight appendixes that provide background information for the task force's work. (Contains 58 references.) (MSE)

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A Model for Differentiated Nursing Practice

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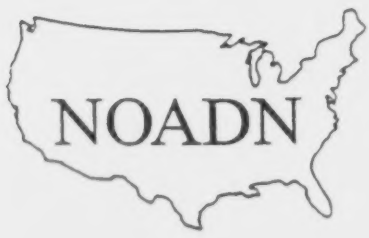

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ACKNOWLEDGMENTS

Support for the AACN-AONE Task Force on Differentiated Competencies for Nursing Practice was provided by a grant from the Robert Wood Johnson Foundation.

The Task Force logo was designed by Sharon Gwin, Graphic Arts Technician, Manatee Community College, Bradenton, FL.

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AACN-AONE TASK FORCE ON DIFFERENTIATED COMPETENCIES FOR NURSING PRACTICE

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EXECUTIVE SUMMARY

Background

In July 1993, the boards of directors of the American Association of Colleges of Nursing (AACN) and the American Organization of Nurse Executives (AONE) met in order to develop a formal set of goals and activities that would facilitate rational work force planning. By the meeting's conclusion the boards developed a clear consensus regarding the need for better delineation of the competencies that are necessary to provide for effective and efficient use of all nursing workforce personnel and for more efficient use of the variety of programs that prepare nursing personnel. To address this need, a joint AACN-AONE task force was established and charged with developing a plan that would provide for rational workforce planning based on a differentiated set of nursing personnel and differentiated practice expectations for a changing health care environment.

Task Force Activities

Over an eighteen-month period the task force met several times to identify current differentiated practice and education efforts; to develop a model for differentiated education and practice inclusive of associate, baccalaureate, and master's level nursing education; to identify a value-neutral terminology that describes differentiated clinician roles; and to develop a plan for the dissemination of differentiated practice and education models that allow rational workforce planning. Throughout this process a number of guests were invited to speak to the task force on differentiated nursing practice models and a values framework.

Differentiated nursing practice has been a goal of nursing professionals for almost a decade. Differentiated nursing practice can be defined as "the practice of structuring nursing roles on the basis of education, experience, and competence (Boston, 1990). Current models of differentiated practice and education, particularly the Colorado Experiment, the Healing Web Project, and the Sioux Valley, South Dakota Differentiated Nursing Experiment, were extensively reviewed by the task force. Due to the successful work accomplished within these models, the task force agreed not to develop a new model for differentiated practice but rather to build on the efforts of these models.

Both organizations agreed from the start that any discussion regarding the future workforce must include representatives of both associate degree nursing education and community and long-term care delivery organizations. Consequently, representatives for these two constituencies were asked to join the task force.

Recommendations

The inclusive nature of the task force led to the development of a number of conclusions and recommendations endorsed by all members of the task force.

- **Models of Differentiated Education - Practice**
  Five to ten differentiated education-practice demonstration projects should be instituted at various sites across the country. Each site chosen as a demonstration site will be required to make a commitment to implementing a program of education and practice differentiation. Sites applying for demonstration status will be required to provide a commitment from the relevant clinicians, educators, and administrators in the participating organizations. Educators must include

representatives of both associate degree nursing (ADN) and baccalaureate degree nursing (BSN) programs. Moreover, model sites will be required to make a commitment of resources and facilities. Due to the move away from a hospital-centered health care delivery system, the model of differentiated practice must also be implemented in varied health care delivery sites in which nursing roles can move across environments or from one setting to another.

- **Development of a Core of Leaders for Differentiated Education-Practice Projects**
  A Leadership Institute should be created to develop a core of nurse educators and administrators who will be charged with the responsibility for implementation and support of the differentiated education-practice demonstration projects. The institute will introduce the participants to the principles and implementation of differentiated education and practice with specific content directed at understanding the successful existing models. Site visits to those settings where successful differentiated practice models have been implemented could be incorporated into this learning process.

- **Continued Development of Value-Neutral Language**
  Continued work must be done to further develop a value-neutral language to describe differentiated nursing practice and education. A value-neutral terminology to appropriately describe the differentiated roles will strengthen the dissemination process across health care education and practice settings.

- **Development of Plans for Further Dissemination**
  All members of the expanded task force expressed a commitment to honoring and mutually valuing the unique contributions of the diverse universe of nursing and to represent the work of the task force to larger communities in order to recommend and elicit support for the goals and future implementation of this initiative. Current efforts toward differentiated practice and education must be supported, and they must continue to be reviewed to avoid previous shortcomings of differentiated experiments. Resources must be made available to disseminate the work of the task force to diverse health care practice and educational settings across the country. In addition, alternative means of implementing the model in geographic areas in which both associate degree nursing and baccalaureate degree nursing programs do not exist must be found. This will include exploration of long-distance learning modes and the use of technologies to provide joint learning experiences.

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The American Association of Colleges of Nursing is pleased to have been able to collaborate with the American Organization of Nurse Executives and the National Organization for Associate Degree Nursing to develop a model for differentiated education and practice. The dynamic changes that the health care system is undergoing mandate serious study of how to allocate scarce resources for education and practice. This groundbreaking activity will provide a national statement that nurses with differing educational and practice skills bring different capabilities to the patient care system and should be able to practice according to those differences.

We look forward to continuing the collaboration between these groups, and we hope that the initial work of the task force will provide a framework for implementation of differentiated education and practice activities.

Sincerely,

Rachel Z. Booth, PhD, RN
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The American Organization of Nurse Executives values its collaboration with the American Association of Colleges of Nursing and the National Organization of Associate Degree Nursing to develop a model for differentiated education and practice. In this rapid changing health care environment, nursing education and practice leaders have a unique opportunity to design new and better approaches to patient care. We believe these approaches can only be developed through collaboration and appreciate the opportunity to participate in this important endeavor.

Sincerely

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ASSOCIATE DEGREE NURSING PERSPECTIVE

The National Organization for Associate Degree Nursing represents the largest number of graduates prepared annually for registered nurse licensure, and as such is enthusiastic about the concepts inherent in this project and the ultimate benefits to the profession of nursing that it could bring. After reading an excerpt from the original report of the AACN-AONE Task Force meeting, the organization felt strongly that associate degree nursing needed to be represented on a task force which had the potential for strongly influencing changing roles in nursing practice. We also felt that N-OADN was the appropriate link to the project. The commitment of the Board of Directors of the organization to pursue inclusion on the Task Force was enthusiastic and unanimous.

N-OADN has previously acknowledged the need for and continues to support health care reform in the United States but recognizes the new and different challenges it will bring to nurses as well as changes in their practice roles. To meet the demands of health care reform, we believe that it is critically important that approaches be used that recognize that each nurse has value and purpose, and as such will play an important role in it. In addition, the basic premises of this project, built upon the essence of nursing as a series of integrated values, enhances its potential acceptance as a model far different from the traditional, incremental, competency-based models of the past. The need to be particularly sensitive to the divisive issues which have historically separated groups of nurses also is a key aspect which influences this project.

Bringing together educators from the two entry level RN programs and nursing service representatives in a locally-based collaborative effort to respond to specific community needs is the logical approach for a successful result. Further, involving students in the process of identifying differentiated practice roles as a part of their educational program strengthens their understanding and acceptance of their equal, yet different and complimentary nursing roles.

N-OADN is fully supportive of this project and in participating in the further development and implementation of it. We believe that associate degree registered nurses will continue to be a significant force in future health care delivery systems and that they should be knowledgeable of and participate in the design of practice roles within these arenas. This project will provide opportunities for them to do so.

I. BACKGROUND

Currently, health care systems are undergoing a sea change that will require a nursing workforce targeted in its capabilities, efficient in its work, and productive in a cost-effective manner. This mediates against production of nursing clinicians who are "all things to all people." In July 1993, the boards of directors of the American Association of Colleges of Nursing (AACN) and the American Organization of Nurse Executives (AONE) met for the purpose of developing a formal set of mutual goals and activities that would facilitate rational work force planning. At this meeting, the two organizations discussed nursing education and practice issues and the elements of change necessary in the current environment of health care delivery and reform. Clear consensus was expressed regarding the need for better delineation of the competencies that are necessary to provide for effective and efficient use of all nursing workforce personnel and for more efficient use of the variety of programs that prepare nursing personnel.

The development of workforce projections in nursing has been a challenging goal. The variety of nursing programs and nursing clinicians produced in these programs has resulted in a mix of providers with different sets of skills yet similar role expectations. Moreover, nursing workforce supply and demand frequently have lacked synchrony as the health care employment market fluctuated, often with production in the various programs having no relationship to need.

Differentiated nursing practice has been a goal of nursing professionals for almost a decade. Differentiated practice can be defined as the practice of structuring nursing roles on the basis of education, experience, and competence" (Boston, 1990). In 1984, the Kellogg Foundation funded a three-year project entitled the National Commission on Nursing Implementation Project (NCNIP). One of the purposes of that project was to facilitate differentiated practice in nursing in response to recommendations by the 1983 Institute of Medicine (IOM) report, *Nursing and Nursing Education: Public Policies and Private Actions*, and the National Commission on Nursing's (NCN) 1983 publication, *Summary Report and Recommendations*. The NCN report recommended that the Midwest Alliance in Nursing (MAIN) develop differentiated practice competencies. In fact, MAIN did produce seminal work on differentiated competencies.

An overriding concern of NCNIP was consensus development regarding the future nursing workforce. NCNIP had many salutary effects on the organization and delivery of nursing care, including facilitating strong cooperative efforts among nursing organizations to redesign the profession's education, practice, and information systems. During NCNIP's existence, a severe nursing shortage was experienced in the health care industry. Because critical shortages of

registered nurses were experienced by many parts of the health care industry, concerns about differentiating the nursing work force's education and practice were allowed to become secondary to other concerns. Rather, a focus was placed on expansion of enrollments in the nation's nursing schools and improving the public's awareness of nursing as a desirable profession. Despite this, differentiation of education and practice were given detailed examination and study by a range of clinical and educational entities. Also, the Midwest Alliance in Nursing (MAIN) continued work on differentiation of nursing practice competencies.

Currently, the dynamic environment for health care delivery is dramatically shifting the principles that organize the delivery of health care services. As managed care organizations have achieved growing prominence as the prime deliverer of health care services, cost-efficiency has become the overriding principle of health care organizations. Increased focus on rationalization of work force resources is creating a growing interest in examination of the unique skills and knowledge of all health professionals, including nurses.

The growth in managed care organizations has also generated intense discussion regarding the size of the acute care sector, the major employment site for nurses. In 1992, according to the Department of Health and Human Services, almost two-thirds of all professional nurses were employed in hospitals. Currently, few data are available to provide a comprehensive view of how the employment picture has shifted or is continuing to shift. Anecdotal reports of downsizing of both hospital size and the work force in these settings have raised growing concerns about both the skill mix necessary for nurses in this environment and the work site transitions that will be necessary in this evolving health care system.

In the midst of this health care delivery dynamic exists a nursing education system that is reexamining the educational programs that prepare basic and advanced practice nurses. A number of important documents have been developed that frame the shifts that must occur. In 1993, AACN produced a report on educational reform at the baccalaureate and graduate levels detailing the curricular elements that must be incorporated into relevant nursing education programs. The Pew Commission on the Health Professions identified the competencies for a changing health care system and an increasing aging and diverse population.

Any changes in nursing education must explicitly recognize that different nursing competencies are needed in the health care system and that the variety of educational programs that exist must more economically direct their resources to preparing a differentiated product. Moreover, the process of transition to a restructured delivery environment and an educational system that

prepares nurses for differentiated practice must include all relevant parties. A process that includes both the educators and employers of the nursing workforce increases the potential for development of a realistic and acceptable approach to rational workforce planning and production.

II. PROCESS

Out of this environment, the boards of directors of AACN and AONE established a joint task force charged with developing a plan that would provide for rational workforce planning based upon a differentiated set of nursing personnel and differentiated practice expectations for a changing health care market. Task force members were drawn from AONE -- JoEllen Koerner, nurse executive, Sioux Valley Hospital; Julie MacDonald, nurse executive, Lutheran Hospital; and Judith Miller, past-president of AONE and nurse executive, New England Deaconess Hospital; and AACN -- Rosalee Yeaworth, University of Nebraska College of Nursing; Carole Anderson, Ohio State University School of Nursing; Fay Raines, University of Alabama, Huntsville; and Kathleen Bond, University of New Mexico School of Nursing.

There was wide agreement in both organizations that any discussions regarding the future workforce must include representatives of both associate degree nursing education and community and long-term care delivery organizations. Two additional representatives for those constituencies -- Cathy Michaels, representing community and long-term care delivery, and Carol Singer, current president of the National Organization for Associate Degree Nursing, were asked to join the task force. This widely representative group was assembled to assure that all constituencies were included in the process of designing a mechanism for rationalizing the education and practice of nursing.

The task force was charged with achieving the following outcomes:

1. identification of current efforts to implement practice or education differentiation;
2. development of a model for differentiated education and practice that was inclusive of associate, baccalaureate, and master's level nursing education;
3. identification of a value-neutral terminology that describes differentiated clinician roles; and
4. development of a plan for dissemination of differentiated practice and education models that allow rational workforce planning.

The Robert Wood Johnson Foundation provided support for this planning process via a nine-month grant for completion of this first phase of the project. Funds were made available to support travel for task force members, some minimal staff time, development of a framework for achieving differentiated practice and education, and dissemination of the phase one outcomes. Seven meetings were held, three of which were in-person. Face-to-face meetings were coordinated with other organizational activities to decrease the associated travel costs. In addition, the second in-person meeting, held June 26-28, 1994 in Minneapolis, Minnesota was coordinated with the International Healing Web group, leaders in the study and practice of differentiation. This meeting allowed greater exploration of the work already in process and established links for future expansion of differentiation projects. Broad discussion occurred about the barriers and facilitators to this experiment. Moreover, the Healing Web participants requested to be allowed to continue in a collaborative role as the task force continued its work.

III. IDENTIFICATION OF CURRENT EFFORTS

The task force began its undertaking by exploring the important work already in process toward the goal of differentiated education and practice. Demonstration projects are being conducted in a variety of locations that experiment with differentiated learning and practice experiences for nurses. The task force concluded that current efforts should be built upon, not duplicated, to enhance current successes.

A. The Colorado Experiment

In 1988, a statewide initiative was introduced in Colorado as a result of growing concerns about recruitment to nursing as a profession. At the request of then-Governor Richard Lamm, representatives of the diverse components of the nursing profession developed two sets of recommendations, which continue to be important in that state. First, a statewide plan to facilitate articulation of nursing education programs of various length and type was completed. The final goal of the articulation plan was to assist nurses to move from one educational credential to another without unnecessary replication of learning or curricular experience. Second, a differentiated model for nursing practice was developed to facilitate appropriate utilization of nurses with varying educational credentials and degrees of experience. Moreover, a differentiated pay scale was recommended by this model to allow appropriate compensation of nursing personnel as career advancement or growth occurred.

A complex and detailed set of competency statements, job descriptions, and evaluative tools was developed as a part of this experiment. Definitions of competency within each role also were developed to characterize career growth within each distinct role (e.g., the associate degree nurse, the baccalaureate degree nurse, and the master's degree nurse).

Included in this model was the clear expectation that movement from one role to another required addition of the appropriate degree, although growth within each role was possible without acquiring formal education. Also, implicit in this model was the understanding that expertise can be attained within each role. Although this model was initiated in 1988, wide scale implementation has not occurred.

B. The Healing Web Project

One wide scale activity, titled the Healing Web Group Project, is a direct outgrowth of the NCNIP-initiated MAIN differentiated competencies work. As noted above, MAIN, through the work of Dr. Peggy Primm, developed the first explication of competencies for differentiated nursing practice. In 1984, as part of the Kellogg Foundation-sponsored NCNIP activities, MAIN was charged with the responsibility for specifically defining the competencies necessary for nurses practicing in differentiated roles. Two types of differentiated practice were defined by NCNIP: assessment-based and education-based. Education-based practice was differentiated according to the educational credentials of the care provider. Assessment-based differentiation was based upon the education and experiential learning that the provider brought to the care environment. The latter was deemed the most commonly used form of differentiation.

General statements defining the ADN and BSN roles were developed to describe the broad practice parameters for each clinician. In addition, specific competencies for direct care provision, communication activities, and management were developed as well as role-specific job descriptions. The competencies for each role were developed out of a consensus process that included input from nurse executives, nursing clinicians, and nurse educators. The primary goals of this effort were to develop clarity about the role expectations of new graduates and to develop mechanisms for ease of transition from student to clinician. The Healing Web Group includes representatives of nursing education and practice from six Midwestern and Western states. These individuals have joined together to design, implement, and evaluate a variety of educational and practice differentiation activities. These projects serve as a model for the types of differentiation that must occur both in practice and education. In addition, they serve as a model of collaboration between nursing education programs and between education and practice.

In a Healing Web Group project site located in Sioux Falls, South Dakota, the most detailed implementation of practice and education reform has been in place for over six years. Moreover, this project is the only effort directed at a differentiated educational design. In this project, nursing students in associate and baccalaureate degree nursing programs are educated in a concurrent clinical laboratory experience to differentiated roles. At Augustana College's baccalaureate nursing (BSN) program and the University of South Dakota's associate degree (ADN) program, a collaborative model of differentiated practice has been integrated into their respective baccalaureate and associate degree nursing education programs. Faculty and students use a differentiated curriculum that provides learning experiences specifically targeted to the competencies and values associated with the two entry-level program types.

C. The South Dakota Experience

Implementation of this unique clinical learning laboratory experience is conducted at Sioux Valley Hospital in Sioux Falls, South Dakota, which has incorporated differentiated roles for nursing staff. Associate degree (ADN) and baccalaureate (BSN) nursing students are partnered for every clinical experience for one full year. The partnered students work as a team, attend post-clinical conferences, present patient care conferences, and at the end of each semester conduct a seminar with case presentations. Experience with this unique learning activity has confirmed that little differentiated learning has occurred prior to this joint activity.

During the first semester, both the BSN and ADN students have a comfortable level of knowledge for practice in the associate degree nursing role. Moreover, there is little differentiation in the care activities conceptualized by the BSN and ADN students. By the end of the first semester, however, clearer differentiation of roles has been established for these two learner groups. The growth continues into the second semester. With a clearer understanding of the differentiated roles, team learning directed at establishing the unique goals for the roles allows development of entry level competence for differentiated practice. The sharing of roles and movement into the differentiated practice roles is a fluid process, which requires that students and faculty explicitly articulate the expectations for differentiated practice.

Other partnerships must be developed between the student and staff, faculty and staff, faculty and faculty, and faculty and unit director. Staff must feel ownership and identify with the differentiated practice model and must be allowed to participate in the students' education and clinical experiences.

The purpose of joint education seminars held throughout each semester is to build teams, educate on differentiated practice, and provide real world orientation. Unit staff and the director participate in the seminars along with the faculty and students from each of the programs. Situational vignettes are used to identify the unique and differentiated nursing roles in specific patient care situations. Students are asked to identify how this differentiation process affects the care delivery process and to reflect upon nondifferentiated care practices and how care outcomes would be changed if differentiated practice were not present. Students are assisted with establishing desired outcomes. Through this process, students gain an appreciation for the unique contributions of nurses in differentiated roles and establish a framework for valuing differences and the importance of these differences to the care process. Students learn that the unique interaction of differentiated roles cannot be changed without affecting the care provider's ability to achieve desired patient outcomes.

Implementation of a differentiated practice clinical learning model does not require major curricular change. Instead, the process for teaching the content and the environment in which it is taught are the elements that must change. Implementation must include collaboration between ADN faculty, BSN faculty, and nursing practice administrators. A discussion of differentiated learning activities is included in Appendix G.

D. Benefits of Differentiated Practice

Both economic and qualitative advantages exist for designing structures that enable the most effective and efficient utilization of human resources. Nurses are more satisfied when their career aspirations and skills match the role responsibilities assumed in ways that optimize their practice. This model allows not only for differentiation of nursing practice but also for the appropriate recognition and rewards along the continuum within each differentiated nursing role.

Significant cost savings have been demonstrated through the use of this differentiated practice model at Sioux Valley Hospital. The implementation of differentiated practice along with shared governance and case management in an extensive six-year process has resulted in decreased lengths of stay, decreased intensive care days, decreased numbers of readmissions, and decreased numbers of inpatient days. During one evaluation of a six-month test period for 35 complex patients, the cost-savings for this institution totaled $552,666. The fiscal impact for the entire project is described in a case study report in Appendix H.

The guiding principle used for the implementation and continued refinement of this care delivery model was to place the highest quality-lowest cost provider next to the patient, based on the

patient's individual needs at any particular stage of his or her illness or event. Examining the hospital's Medicare book of business for the past two years revealed that from 1992 to 1994 the average cost per patient decreased and the average reimbursement increased. Sioux Valley Hospital was identified in January 1994 and again in November 1994 as one of the "100 Top U.S. Hospitals-Benchmarks for Success" as reported in *Modern Healthcare*. To qualify, hospitals had to rank above their peers on eight measures of effectiveness and efficiency in clinical practice, operations, and financial management. Editors for *Modern Healthcare* indicated that if all U.S. hospitals were performing at the benchmark levels exhibited at Sioux Valley Hospital, the savings to the health care industry would be significant, including a decline of $21 billion in expenses, a decrease of 17 percent in average length of stay, a decline of 14 percent in complication rates, and a decline of $43 billion in hospital charges. Most importantly, the major factor cited for Sioux Valley's success is the unique differentiated nursing system.

IV. DEVELOPMENT OF A MODEL FOR DIFFERENTIATED LEARNING AND PRACTICE

A. Assumptions and Values

Clearly, much effort has been already directed at articulating the components of differentiated practice. However, implementation of differentiated practice has been minimal primarily due to the intervening nursing shortage that occurred in the 1980s. Therefore, for this task force, a major focus was placed on how to educate current nurse clinicians to practice in a differentiated environment and how to design nursing systems that facilitate differentiated practice.

As noted above, the most sophisticated implementation of differentiated educational experiences is in place at Sioux Valley Hospital, a member of the Healing Web Project. Therefore, the task force agreed to build on previously successful work by expanding the work done by the Healing Web. The task force agreed to develop a clear explication of the assumptions, principles, values, and process that must be actualized to provide a more wide scale implementation of this successful effort.

The task force began its work through a process of identifying the assumptions and values that are held jointly by education and practice. A framework built upon mutually held assumptions and values provides a unifying thread for mutually agreed upon goals and process. The task force achieved consensus on the following assumptions and values for the profession of nursing and for the task force's work.

The assumptions for the profession of nursing were:

1. A less value-laden terminology to describe nursing roles must be developed.
2. The essence of nursing does not change with setting or role.
3. Nursing is a process and not a constellation of tasks. The unique function of this task force should be to focus on process, not a series of definable tasks.
4. Empowerment of the individual patient or client is critical to nursing practice. The individual client or patient makes choices based on information provided by the nurse.
5. Differentiated practice is aimed at improving the quality of care delivered and in the most cost-effective manner.

The assumptions and values agreed upon for the task force's work were:

1. The future, not current practice, would be the frame of reference. Managing transition would be one of the most important steps in attaining the future of nursing as envisioned by the Task Force.
2. Differentiated nursing capacities should be presented for practice across the continuum of care for the variety of nursing education pathways.
3. Participation from a wide variety of constituents in this process is necessary to assure that the process outcomes will be accepted by nurses from all types of educational backgrounds and to assure development of capacities that are relevant to the evolving practice environment.
4. Different nursing roles are or must be mutually valued.

B. Values as a Core and as a Mechanism for Differentiation

These shared assumptions and values provided the task force with a frame of reference for determining the appropriate mechanism for defining differentiated capacities and for development of differentiated educational processes. Shared values serve as an integral guiding principle for norm directed action and behavior across the practice of nursing. The type and extent of care rendered by any individual nurse is directly related to the nurse's own value orientation. It is these personal values of each nurse coupled with the shared values of the discipline that guide the critical thinking and decision-making that ultimately shape the resultant action in each clinical encounter. Thus, a unified set of professional values provides a normative framework for the practice of nursing. The combination of competencies (skills) and values forms the "essence" of nursing.

Professional socialization is achieved through the development of shared assumptions and values (i.e., core values). The clustering of these core values along with individual practitioner's unique (instrumental) or differentiated values creates his or her world view. These clusters or sets of

values can be used to differentiate various professional groups (Hall, 1986, p.27) and form a belief system that guides and shapes differentiated nursing practice patterns. From this foundation the nurse selects responses appropriate to the client situation, establishes ethical parameters for decision-making, and determines the standard of care to be reached.

C. World Views and Differentiated Practice

The task force reviewed the work of Koerner and the AACN document identifying values and competencies for baccalaureate nursing education -- *The Essentials of College and University Education for Professional Nursing*. Review of the original *Essentials* document revealed that much of the work originally conducted by AACN was still relevant to the current effort. (See Appendix A)

In addition, much work has been done by the International Values Institute to specify the value sets that are incorporated in world views. Hall (1986) noted that four world views are represented by values:

1. Surviving - represents safety and security, and focuses on skills as a means of maintaining security (20% of the entire population);
2. Belonging - focuses on kinship and group identification within the family and institution (60% of population);
3. Self Initiating - focuses on independent decision making, trusting self and one's vocation and a new order (16% of population, 2% of women); and
4. Interdependent - sees a broader view of world order and the interconnectedness of self and others (4% of population, e.g., Mother Teresa).

Within these broad world views or value sets, three types of values are identified by Hall (1986): goal, means, and motivational values. Within each group or type of values, shared and unique clusters of values also were identified, which help to further define differentiated nursing roles. For further definition of these unique clusters of values see Appendix D.

A detailed review of research conducted by Koerner provided evidence that shared and differentiated value sets also exist for nursing professionals. Moreover, instrumental value sets were shown by Koerner to vary according to nursing roles as defined by educational background. Koerner concluded that the decision-making and role-related behaviors of nurses that express these values can be differentiated. Profiles of the "Value Sets of Differentiated Nursing Roles" also are shown in Appendix D.

Koerner identified differing value sets for nurses working in differentiated roles within the broader discipline of nursing. Nurses with ADN competencies were shown to have a value base within the belonging phase of value development; nurses with BSN competencies were shown to overlap two value sets -- belonging and self-initiating; master's-prepared nurses function within the self-initiating value base; and leaders in nursing function in the high end of the self-initiating world view (Koerner, 1993; see Appendix D).

The time/space orientation of the differing nursing practice roles also varied. (For a more extensive explanation of time/space orientation in general see Appendix E.) ADN nurses worked within a time frame that was present-based; BSN nurses focused on the present as a means for achieving future outcomes (Koerner, 1993). These differences were evident in the differentiated practice models currently being implemented by the Healing Web Project at Sioux Valley Hospital and other sites. The ADN nurse worked within clearly defined paths and organized care from a base of the norm or usual illness experience with predicted outcomes regardless of the care setting. The BSN nurse was able to assimilate the present, the norm, and significant variation within a plan for intervention. The BSN nurse provided care across settings in which outcomes are more ambiguous and in situations that require the utilization of more complex data and coordination of more extensive resource application. The MSN nurse functioned within a broader view that included the use of various systems' components for highly complex ongoing client situations across settings and the lifespan.

The task force agreed that a focus on these clusters of values, the areas of overlap, and the areas of differentiation should serve as the framework for this project. By identifying exemplars in these practice roles and delineating the behaviors and capacities that are present in the differentiated roles, practice and curriculum models can be constructed. Exemplars of patient care utilizing this differentiated practice model are presented in Appendix F.

V. DEVELOPMENT OF A VALUE-NEUTRAL TERMINOLOGY

A. Nursing in Transition

If nursing's work were just beginning today, it would be a relatively straightforward job to design the roles, education, and professional socialization process for nurses using the above differentiated values sets and time/space orientation. Developing a blueprint for implementation and operationalizing it within a predictable time frame would likely occur with minimal obstacles. This has not happened. Not because there is neither agreement on both the essence and ideal

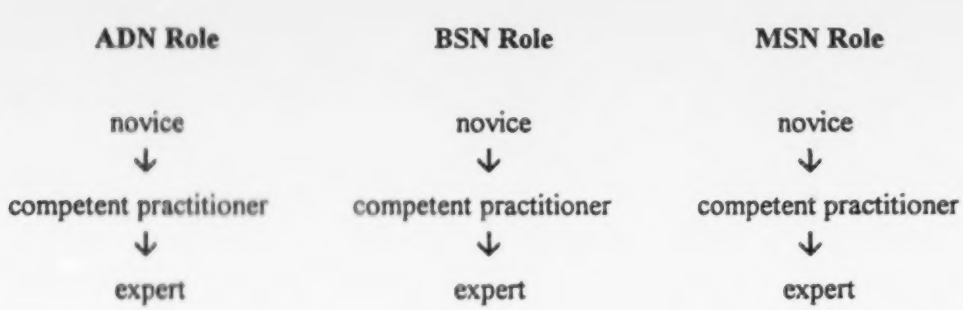
state of nursing practice, nor acceptance of the need for change to ensure the future of nursing, but due to the transition differentiation poses for nurses presently in the profession who have been educated to practice in nondifferentiated roles.

Moving an existing nursing workforce into differentiated practice roles creates uncertainty about the uncharted territory represented by new roles. Nurses in practice fear of losing credibility related to expertise they have gained through years of experience. Moreover, the new skills that will be required in a shifting care delivery system, and the social environment for the practice of nursing create a new domain for the profession that is uncharted. In addition, implementing the recommendations presented in this monograph will require the reconfiguration of nursing systems to facilitate differentiated roles.

Three key *fundamental* strategies are necessary in the management of this transition. The first requires the maximum utilization of the talents existing in each member of the current nursing workforce regardless of the educational credential held. The second strategy requires the application of principles of differentiation and mutually valued practice. It is critical to create roles that are different, not one role greater than the next. Also roles must be created that compliment each other at the essence yet differ in the skills required. The third and probably most important strategy relates to the resocialization of nurses to actively value and understand, in a new way, the whole of nursing's work.

The differentiated roles within this model are assessment based and reflect both educational credentials and competencies gained in practice of ADN, BSN, and MSN clinicians. Individuals currently practicing nursing could move in to one of these three practice roles through education or experience. As differentiated education and practice of nursing evolves, education would become the mechanism of entry into any of the three differentiated practice roles. Within each nursing role (ADN, BSN, MSN) the individual will be expected to move in a continuum from novice to competent practitioner to expert. This model of differentiation, shown in Figure 1, does not imply a lateral move from one role to another as an individual becomes "expert" or more experienced in practice and the delivery of nursing care.

Figure 1. Model of Differentiation



This transitional process requires movement of the profession from a prescriptive task focus to a reflective process focus. In the emerging health care environment, which is complex, diverse, and spread across the continuum of care delivery sites, nurses must interact with the client or family in multiple settings, responding to ever changing needs. Nurses, therefore, must be able to examine the problem, the context, and the overall needs and expectations of the clients from their unique biological and cultural perspective. This requires nurses to be clinically competent as well as flexible and imaginative in their provision of nursing care. More importantly, this requires matching the unique capabilities of nursing clinicians with patient care requirements.

B. Separate Mutually Valued Roles

In a differentiated practice environment, nurses must understand and value the differing roles and capacities of all nurses, consulting with and referring to other nursing colleagues when appropriate. In this way, each client will have access to the full scope of nursing services across the continuum of care in a timely and cost-effective fashion. By moving to a differentiated model of practice nursing will be positioned strategically in a restructured health care system to ensure delivery of high quality cost-effective care.

Mutual valuing and awareness by those practicing in the different roles is also critical in this differentiated practice model. Collaborative relationships among nurses practicing in the various nursing roles must be based on mutuality; each person's expertise is recognized as necessary for the provision of the highest quality care. Mutual valuing leads to growth, discovery, and insight into one's self and respect for the other practice roles. Relationship is the foundation for nursing practice; relationship with the client and family, as well as relationships among the various nursing roles within a differentiated professional community replaces the old "a nurse is a nurse" paradigm.

Through the education and socialization processes the realization that one nurse (or type of nurse) cannot fill all nursing roles must be developed. All three integrated nursing roles are needed to provide high quality and comprehensive health care to all patients in all settings. Ideally, BSN and ADN students should work side by side so they can learn how both roles contribute to the patient's care. If both types of students are not present in one geographic area, differentiated practice role models must be present in the various clinical settings.

C. Toward a Neutral Terminology

The Sioux Valley experience resulted in terminology for the differentiated practice roles mutually developed by nurses practicing in each of these roles. Much of the professional tension associated with differentiation of roles has focused upon appropriate terminology to describe the roles. At Sioux Valley, the titles "associate nurse" and "primary nurse" were developed to represent the associate degree and baccalaureate degree nursing roles, respectively. "Associate" was an acceptable term because of its widespread use in other disciplines to designate professional roles (e.g. associate professor or associate of a law firm). "Primary nurse" was agreed upon because of the time span associated with the baccalaureate role at Sioux Valley with the BSN nurse functioning across settings and over the time span of the hospitalization.

However, continued discussion regarding appropriate titling for differentiated roles must be a component of any attempt to differentiate education and practice. Several elements are essential to the designation of appropriate titles for the roles. First, the titles must be mutually derived. Second, the titles must connote differences, not hierarchical assessments of value. In this report, the terms "associate degree nurse," "baccalaureate degree nurse," and "master's degree nurse" represent an attempt to separate roles with neutral terms. Finally, the titles and roles must reflect differentiated nursing practice across a diversified health care environment.

VI. DEVELOPMENT OF DISSEMINATION PLANS AND MODELS FOR DIFFERENTIATION

A. Conclusions

The differentiated roles within nursing are each separate and distinct entities as depicted in the project logo shown in Figure 2. Yet each of the differentiated roles is held together by the integrated values or essence of nursing. This model of nursing assumes the need for and existence

of each role in a comprehensive health care system. The education and preparation of clinicians for each of these roles must also be separate but collaborative processes.

Figure 2. Project Logo

The task force members strongly endorsed the appropriateness of value sets for development of differentiated role competencies and the design of systems for differentiated education and practice. The following conclusions were endorsed:

1. Core values and unique (instrumental) values can serve as the basis for decisions and points of focus that differentiate activities that are role related.
2. Nursing practice differentiation is based upon time frame (shift vs. life span), space (unit vs. the community), and motion (capacity to integrate).
3. The ability to handle variables of increased complexity or density is gained through education and practice.
4. The model of differentiated nursing practice and education being implemented by the Healing Web Project is cost-efficient and promotes high quality nursing care across settings and the life span for all consumers of health care and also job satisfaction for nurses.
5. To ensure nursing as an integral and permanent component of the future health care system, differentiated nursing practice must be implemented in all health care practice settings and differentiated roles must be taught in ADN and BSN education settings as well.
6. All three integrated nursing roles are necessary to meet the needs of the future health care system, i.e., to provide high quality, comprehensive cost-effective care to all patients, in all settings.

7. Initially, differentiation of nursing roles will be based on education, experience, and choice. As the education and practice settings evolve to reflect differentiated practice roles, differentiation will occur through education.

B. Recommendations For the Future

Models of Differentiated Education-Practice. Five to ten differentiated practice demonstration projects should be instituted at various sites across the country. Each site chosen as a demonstration site will be required to make a commitment to implementing a program of education and practice differentiation. Sites applying for demonstration status will be required to provide a commitment from the relevant clinicians, educators, and administrators in the participating organizations. Moreover, model sites will be required to make a commitment of resources and facilities.

Health care systems with strong histories of innovation are needed as demonstration sites. Only one or two units within each system will be chosen to implement the project. Implementation throughout an entire institution would require tremendous organizational shift and upheaval, which could jeopardize the project's success. Implementation of the education model should occur in only one or two courses in both the BSN and ADN programs for similar reasons. Most important will be the commitment of relevant participants and organizational commitment to experimentation.

In the changing health care environment, the hospital will no longer be the center of the health care delivery system. Regional networks of health care facilities will be formed. The patient will move throughout the system from one setting to another and encounters will go beyond one episode of illness and encompass the entire life span. Due to these anticipated changes in the health care arena, the model of differentiated practice must be implemented in varied health care delivery sites in which nursing roles can move across environments or from one setting to another. An important part of this demonstration will be the inclusion of representatives of the range of organizations that are engaged in experimentation with differentiated care activities. Current efforts toward differentiated education and practice must be supported. Moreover, continued expansion of differentiated practice and education must be reviewed to avoid previous shortcomings of the differentiation experiments.

Development of a Core of Leaders for Differentiated Education-Practice Projects. Prior to establishing the demonstration projects, the Task Force recommends that a Leadership Institute be created to develop a core of nurse educators and administrators who will be charged with the

responsibility for implementation and support of the differentiated practice demonstration projects. The institute will introduce the participants to the principles and practice of differentiated education and practice with specific content directed at understanding the successful models that have been implemented. Using tools such as active listening, mutual valuing of others and their roles, the philosophy and assumptions behind the model and the implementation of the differentiated practice and educational models will be explored. Problems associated with implementation of the model also will be addressed in this forum. In addition, agencies or various health care delivery sites that will be sites for clinical training will participate in the institute to foster development of differentiated practice initiatives.

Continued Development of Value-Neutral Language. The Task Force endorsed the continued development of a value-neutral language to describe differentiated practice. A value-neutral terminology to appropriately describe the differentiated roles will strengthen the dissemination process across health care practice and education settings.

Development of Plans For Further Dissemination. Current efforts toward differentiated practice and education must be supported. These efforts toward differentiated practice and education must continue to be reviewed to avoid previous shortcomings of differentiated experiments. Resources must be made available to disseminate the work of the task force to diverse health care practice and educational settings across the country. In addition, alternative means of implementing the model in geographic areas in which both ADN and BSN programs do not exist must be found. This will include exploration of long-distance learning modes (such as satellite telecommunications) and the use of technologies to provide joint learning experiences.

C. Commitment of the Task Force

The members of the expanded task force completed their work on Phase I of this project with a clear commitment to the project's goals and process. All task force members expressed a commitment to honor and mutually value the unique contributions of the diverse universe of nursing represented in the group. The group also made a strong commitment to represent the task force's work to larger communities in order to recommend and elicit support for the goals and future implementation of this initiative.

APPENDIX A

ESSENTIALS OF BACCALAUREATE EDUCATION

In 1984, AACN received a grant from the Pew Memorial Trust to define education for professional nursing. The proposal was based on recommendations found in the *Institute of Medicine Study on Nursing and Nursing Education* (1983) and the *Report of the National Commission on Nursing* (1983). The project, entitled *Essentials of College and University Education for Professional Nursing,* was directed by a national panel of representatives from the nursing, health care, and higher education communities. This was the first comprehensive national effort to define the essential knowledge, practice, and values that the baccalaureate nurse should possess. Based on the work of this panel, the essentials of baccalaureate nursing education were delineated and recommended for inclusion in every program.

According to this report, college and university education for professional nursing includes processes that foster the development of values, attitudes, personal qualities, and professional behaviors. Values are defined as beliefs or ideals to which an individual is committed and which guide behavior. Values are reflected in attitudes, personal qualities, and consistent patterns of behavior. Professional behaviors reflect the individual's commitment to specific values (AACN, 1986).

The professional nurse must adopt contemporary characteristics such as independence, assertiveness, self-esteem, and confidence as well as those of a more traditional nature such as compassion, acceptance, consideration, and kindness. Adoption of the essential values leads the nurse to a sense of commitment and social responsibility, a sensitivity and responsiveness to the needs of others, and a responsibility for oneself and one's actions. The following seven values were identified as essential for the baccalaureate-prepared nurse:

Essential Values (in alphabetical order)	**Examples of Attitudes and Personal Qualities**	**Examples of Professional Behaviors**
1. ALTRUISM Concern for the welfare of others.	Caring, Commitment Compassion, Generosity Perseverance	Gives full attention to the patient/client when giving care.

		Assists other personnel in providing care when they are unable to do so.
		Expresses concern about social trends and issues that have implications for health care.
2. EQUALITY Having the same rights, irrespective of privileges, or status.	Acceptance, Assertiveness Fairness, Self-esteem, Tolerance	Provides nursing care based on the individual's needs irrespective of personal characteristics.*
		Interacts with other providers in a non-discriminatory manner.
		Expresses ideas about the improvement of access to nursing and health care.
3. ESTHETICS Qualities of objects, events, and persons that provide satisfaction.	Appreciation, Creativity Imagination, Sensitivity	Adapts the environment so it is pleasing to the patient/client.
		Creates a pleasant work environment for self and others.
		Presents self in a manner that promotes a positive image of nursing.
4. FREEDOM Capacity to exercise choice.	Confidence, Hope, Independence, Openness Self-direction, Self-discipline	Honors individual's right to refuse treatment.
		Supports the rights of other providers to suggest alternatives to the plan of care.

* From CODE FOR NURSES, American Nurses' Association, 1976

		Encourages open discussion of controversial issues in the profession.
5. HUMAN DIGNITY Inherent worth and uniqueness of an individual.	Consideration, Empathy Humaneness, Kindness Respectfulness, Trust	Safeguards the individual's right to privacy. Addresses individuals as they prefer to be addressed. Maintains confidentiality of patients/clients and staff. Treats others with respect regardless of background.
6. JUSTICE Upholding moral and legal principles.	Courage, Integrity, Morality, Objectivity	Acts as a health care advocate. Allocates resources fairly. Reports incompetent, unethical, and illegal practice objectively and factually. *
7. TRUTH Faithfulness to fact or reality.	Accountability, Authenticity, Honesty, Inquisitiveness, Rationality, Reflectiveness	Documents nursing care accurately and honestly. Obtains sufficient data to make sound judgments before reporting infractions of organizational policies. Participates in professional efforts to protect the public from misinformation about nursing.

* From CODE FOR NURSES, American Nurses' Association, 1976

Nursing science stems from the inner core values of the collective profession, which serve as a foundation for the current theories in nursing, as well as the code of Ethics for Nurses (ANA, 1978). The professional nurse assigns priorities to these values within specific decision-making contexts in the application of essential knowledge and practice. Values, attitudes, personal qualities, and consistent patterns of behavior are fostered and facilitated by selected educational strategies and the process of socialization to the profession (AACN, 1986).

Shared values serve as an integral guiding principle for norm-directed action and behavior among the varying roles. External to the common set of shared values are sets of values that are exhibited or expressed differently among the differentiated practice roles that make up the whole of nursing.

APPENDIX B

ESSENCE OF NURSING AS A DISCIPLINE

Differentiation of nursing roles encompasses the matching of values, knowledge, and skills of individual nurses to the health/illness needs of the public to whom they minister. It serves little if any purpose, however, to either the public or the profession, if the various roles are not built on a common core of values, knowledge, and practice. This common core of values, knowledge, and practice, the essence of nursing, should not change by nursing role or practice site, but should serve as the fundamental foundation of RN roles and nursing education at all levels.

Since the focus of nursing study is on the human health experience (Parse, 1994), examining health in the context of nursing's essence seems both logical and imperative. Nightingale's simple description of both of these concepts demonstrates their relationship and the process focus of each. She defined nursing as "the care that puts the patient in the best possible condition for nature to act" and described health as not only being well "but to be able to use well every power that we have." Parse's (1994) Theory of Health as Human Becoming supports this notion of human empowerment, honoring patients' rights to choose, and respecting them as expert in their life and health. She related nursing's purpose as "enhancing quality of life as defined by the client." These processes of empowerment, self-discovery, autonomy, independence and partnership with patients in the human health experience are central to nursing's core and essence.

Henderson (1966) further described the process of nursing as "assisting the individual, sick or well, in the performance of those activities contributing to health or recovery (or to a peaceful death) that he would perform unaided if he had the necessary strength, will, or knowledge. And to do this in such a way as to help him gain independence as rapidly as possible." The notion of "necessary strength, will, or knowledge" supports the functional basis of nursing practice and the need to individualize the approach and care based on the patient's response. It, too, requires knowing the patient as a person and their pattern of response. These processes reinforce the concept of individual human experiences as a central theme in Nursing's Social Policy Statement (ANA, 1980) and as an important aspect of nursing's unique contribution in health care (AONE, April 1993). Inherent in the process of diagnosis and treatment of human experiences to health and illness is the ability to understand exactly what health, a health problem, or disability means to an individual. It implies the ability to reframe the problem based on the unique response of the individual and requires one to view the individual holistically. Therefore, processes of assisting,

knowing, understanding, and respecting the unique choices and responses and the wholeness of the individual also become integral to the essence of nursing. In the 1995 draft document of the ANA *Nursing's Social Policy Statement*, the concern of nurses for the individual's experiences with health and illness is broadened to include the individual's experience within the context of families, groups and communities.

As we examine these concepts as the core of nursing across a continuum, the unique role of the nurse begins to emerge. These value-based processes become our social contract with patients and have two underlying accountabilities. The first relates to the ability to assist the patient in a "doing" capacity. This "doer" role (Lamb & Stempel, 1994) is described by patients as the nurse who "knows her stuff" and can meet the patient's emerging physiological needs. This doer role relates to health and illness and would be described by many nurses as that which brings you to the patient and often that which first establishes and positions the nurse with the patient. The second accountability relates to the "insider" role, the ability to "be with the patient." It is being able to see the patients' human health experience through their eyes. This is described by patients as the individual "who knows and cares about all of me" and understands what effect an individual's problem is having on his or her life and how it makes him or her feel (Lamb & Stempel, 1994; Powell, 1993). Each nurse should be ready, willing, and able to be accountable to both dimensions. For it is the needs of each patient in the moment of care that directs the balance of "doing" and "being with."

It is this dual dimension that is both nursing's opportunity and greatest challenge, and is what makes the discipline of nursing unique. These two accountabilities are the core of nursing's essence and should be the foundation of all nursing practice roles. As the patient moves across the continuum from illness to their optimal state of health, an anticipated different balance and depth of these two accountabilities is required. It is both this essence and balance that can serve as the framework for the differentiation of nursing roles.

APPENDIX C

DIFFERENTIATION OF ADN AND BSN EDUCATION AND COMPETENCIES

A fundamental principle of living systems is the fact that their structures become differentiated in regard to the various demands imposed upon them by their environment. Sociologist Parsons (1966) noted that in early tribal society all members performed the same role function. As the social group became more complex through both increasing numbers and increasingly diverse needs, efficiencies had to be built into the system. Thus, some members specialized in toolmaking, while others became hunters or food gatherers. By division of labor and integration of the varied services offered, the tribe increased its flexibility and adaptability in meeting the present and evolving needs of a maturing society. From an evolutionary perspective, a critical function of any social system is the ability to enhance its adaptive capacity if it is to stay viable as the host system becomes more complex. This work begins with the process of differentiation, where a single unit with clear definition divides into units that differ in both structure and function to enhance the wider system. If differentiation is to yield a balanced, more evolved system, each newly differentiated substructure must have increased adaptive capacity for performing its primary function. This adaptive upgrading aspect of the evolutionary change cycle enhances the productivity of the collective (Gleick, 1987).

Differentiated Nursing Practice

> *A sense of crisis has erupted in the nursing profession. The scope of nursing practice is enlarging as a result of rising patient acuity and fragmentation within the health care industry. Rapid organizational diversification and expansion reflect efforts to adapt to the dynamically changing health care environment. Intensifying physician subspecialization increases costs while decreasing productivity as well as enlarging human resource needs. Furthermore, fragmentation and duplication disrupt information exchange while creating an economic imbalance. Nursing is being called upon to assume broader responsibility in integrating the allocation of human, fiscal, and material resources for improved patient care. As nurses' role in primary (and tertiary) care increases, so must their role in clinical care management* (Koerner & Karpiuk, 1994)

Differentiation of roles for the professional discipline of nursing began in World War II when a shortage of nurses in civilian hospitals led to the creation of assistive roles; namely, licensed practical nurses and nursing assistants. When the war ended and the need for nurses did not abate, these position titles were institutionalized. Throughout the remainder of the 20th century, the education and utilization of these two distinct assistive levels have gradually become more formal and codified. Over the past 10 years, new dialogue concerning differentiated practice has focused on the differing roles within professional nursing rather than on the assistive nursing roles.

> *Historically, RNs with different levels of education have been used interchangeably in most health care settings in one role category: nurse. Nursing practice is not systematically differentiated by education, prior experience, and/or additional contribution to the practice. (In addition) without formal recognition or increased compensation, the expert nurse is informally relied upon by patients, physicians, other nurses, and hospital* management *to a greater degree than the novice*. (Koerner & Karpiuk, 1994)

If nursing is to meet the demands of a rapidly changing health care system (expanding and diverse health care delivery environments and sites, growing technology and knowledge bases in the areas of both the physical and social sciences, demands for cost containment, and demands for increased access and quality primary health care), a nursing care delivery model that differentiates scope of job responsibility based on education, experience, and competence must be developed. This will be an evolutionary yet crucial step in the development of professional nursing, which will maximize cost and quality outcomes for clients and health care organizations.

Definition of Differentiated Nursing Practice

Differentiated nursing practice has been defined as " a philosophy that focuses on the structuring of roles and functions of nurses according to education, experience, and competence" (Boston, 1990). It also embodies differentiated sets of values, beliefs, attitudes, and behaviors (Koerner and Karpiuk, 1992; Koerner, 1994). Differentiated nursing roles placed along the continuum of care can match the skills of various nurses to the differing needs of the public they serve.

The concepts of time, space, and motion have a different focus and meaning for various nursing roles placed along the continuum of care (Koerner, 1993). The associate degree nurse (ADN) role functions primarily at the bedside in an institutional setting and in less complex patient care situations. "Associate" nurse implies one joined with others in some common work, or (as in

other professions) the terminology is used to define how individuals align or relate to others in the profession (e.g., associate dean or associate justice). The time frame for care rendered by the ADN is defined within a shift or limited period of time, based on activities that provide comfort, physiological stabilization, or assistance to a peaceful death. The guiding principles of the ADN's work are found in nursing standards, protocols, and pathways. Working with the client and family, this nurse does for the client that which the client is unable to do without assistance, demonstrating an awareness and appreciation of the client's unique strengths and abilities.

The Bachelor of Science in Nursing (BSN) role functions within a horizontal focus or across time from preadmission to postdischarge. The guiding principles of this role are found in the unusual and often unpredictable response of the individual to this health situation, which goes beyond needs addressed in the standards or pathways. Collaborating with other disciplines and agencies, the BSN intervenes to design and facilitate a comprehensive, well-prepared discharge based on the unique needs of the client and family from an "insider's" perspective.

The advanced practice nurse (APN) role, based on Master's of Science in Nursing (MSN) competencies, also functions across the continuum of care in a "timeless" manner. In addition the MSN role is not bound by setting but provides a continuum of care across all settings, working with the client and family throughout wellness, illness, or until death. Based on a perspective supported by in-depth education in physiology, physical assessment, pharmacology, and a broad health care systems perspective, the MSN creates and defines protocols and pathways, and assists with development of standards on emerging new health phenomena. The MSN also utilizes knowledge and expertise in case management to provide comprehensive, coordinated care to the client and the family. This role is based primarily on the "insider" relationship, facilitating the clients in "doing for themselves from an empowered stance" their own care activities, while integrating and coordinating (as circumstances dictate) their physical, psychosocial, spiritual, and financial needs with other provider and payor agencies.

National Commission on Nursing Implementation Project

The National Commission on Nursing Implementation Project (NCNIP) was a three-year project funded by the W.K. Kellogg foundation to provide leadership for nursing's future. The project was organized to coordinate recommendations of the National Commission on Nursing which completed its work in 1983. One of the primary goals of the project was to "outline the common body of knowledge and skills essential for basic nursing practice, the curriculum content that supports it, and a credentialing process that reinforces it" (DeBack, 1987, p.226).

Using a group process approach to achieve regional consensus on competency-based statements of practice expectation for ADN- and BSN-prepared nurses the following statements on differentiated roles and curricula were developed (Primm, 1987, pp. 222-223, reprinted with permission from W.B. Saunders Company).

General Statement on Differentiated Competencies

The ADN cares for focal clients who are identified as individuals and members of a family. The level of responsibility of the ADN is for a specified work period and is consistent with the identified goals of care. The ADN is prepared to function in structured health care settings. The structured settings are geographical and/or situation environments where the policies, procedures, and protocols for provision of health care are established and there is recourse to assistance and support from the full scope of nursing expertise.

The BSN cares for focal clients who are identified as individuals, families, aggregates, and community groups. The level of responsibility of the BSN is from admission to post-discharge. The BSN is prepared to function in structured and unstructured health care settings. The unstructured setting is a geographical and/or situational environment which may not have established policies, procedures, and protocols and has the potential for variations requiring independent nursing decisions.

The reader should assume that the following BSN competencies always include the ADN competencies of the same letter. The competencies within each category build upon one another and cannot be taken out of context.

Role of the Baccalaureate Degree Nurse (BSN)

The BSN is a licensed registered nurse who provides direct care that is based on the nursing process and focused on clients with complex interactions of nursing diagnoses. Clients include individuals, families, groups, aggregates, and communities in structured and unstructured health care settings. The unstructured setting is a geographical or a situational environment that may not have established policies, procedures, and protocols and has the potential for variations requiring independent nursing decisions.

The BSN uses complex communication skills with focal clients. The BSN collaborates with other health team members and assumes an accountable role in change. The BSN assesses the need for information and designs comprehensive teaching plans individualized for the focal client. The BSN collaborates with nurse researchers and incorporates research findings into nursing practice.

The BSN manages comprehensive nursing care for focal clients. The BSN maintains accountability for own practice and for aspects of nursing care based on identified needs of the focal client from admission to post-discharge. the BSN practices within accepted ethical and legal parameters of nursing.

Role of the Associate Degree Nurse (ADN)

The ADN is a licensed registered nurse who provides direct care that is based on the nursing process and focused on individual clients who have common, well-defined nursing diagnoses. Consideration is given to the client's relationship within the family. The ADN functions in a structured health care setting that is a geographical or situational environment where the policies, procedures, and protocols for provision of health care are established. In the structured setting there is recourse to assistance and support from the full scope of nursing expertise.

The ADN uses basic communication skills with focal clients and coordinates with other health team members to meet focal clients' needs. The ADN recognizes the individual's need for information and modifies a standard teaching plan. The ADN recognizes that nursing research influences nursing practice and assists in standardized data collection.

The ADN organizes for focal clients those aspects of care for which s/he is responsible. The ADN maintains accountability for own practice and for aspects of nursing care s/he delegates to peers, licensed practical nurses, and ancillary nursing personnel. within a specified work period, the ADN plans and implements nursing care that is consistent with the overall admission to post-discharge plan. The ADN practices within accepted ethical and legal parameters of nursing.

Provision of Direct Care Competencies

The ADN provides direct care for the focal client with common, well-defined nursing diagnoses by:	The BSN provides direct care for the focal client with complex interactions of nursing diagnoses by:
A. collecting health pattern data from available resources using established assessment format to identify basic health care needs.	A. expanding the collection of data to identify complex health care needs.
B. organizing and analyzing health pattern data in order to select nursing diagnoses from an established list.	B. organizing and analyzing complex health pattern data to develop nursing diagnoses.
C. establishing goals with the focal client for a specified work period that are consistent with the overall comprehensive nursing plan of care.	C. establishing goals with the focal client to develop a comprehensive nursing plan of care from admission to post-discharge.
D. developing and implementing an individualized nursing plan of care using established nursing diagnoses and protocols to promote, maintain, and restore health.	D. developing and implementing a comprehensive nursing plan of care based on nursing diagnoses for health promotion.
E. participating in the medical plan of care to promote an integrated health care plan.	E. interpreting the medical plan of care to nursing activities to formulate approaches to nursing care.
F. evaluating focal client responses to nursing interventions and altering the plan of care as necessary to meet client needs.	F. evaluating the nursing care delivery system and promoting goal-directed change to meet individualized client needs.

Communication Competencies

The ADN uses basic communication skills with the focal client by:

A. developing and maintaining goal-directed interactions to encourage expression of needs and support coping behaviors.

B. modifying and implementing a standard teaching plan in order to restore, maintain, and promote health.

The BSN uses complex communication skills with the focal client by:

A. developing and maintaining goal-directed interactions to promote effective coping behaviors and facilitate change in behavior.

B. designing and implementing a comprehensive teaching plan for health promotion.

The ADN coordinates focal client care with other health team members by:

A. documenting and communicating data for clients with common, well-defined nursing diagnoses to provide continuity of care.

B. using established channels of communication to implement an effective health care plan.

C. using interpreted nursing research findings for developing nursing care.

The BSN collaborates with other health team members by:

A. documenting and communicating comprehensive data for clients with complex interactions of nursing diagnoses to provide continuity of care.

B. using established channels of communication to modify health care delivery.

C. incorporating research findings into practice and by consulting with nurse researchers regarding identified nursing problems in order to enhance nursing practice.

Management Competencies

The ADN organizes those aspects of care for focal clients for whom s/he is accountable by:	The BSN manages nursing care of focal clients by:
A. prioritizing, planning, and organizing the delivery of standard nursing care in order to use time and resources effectively and efficiently.	A. prioritizing, planning, and organizing the delivery of comprehensive nursing care in order to use time and resources effectively and efficiently.
B. delegating aspects of care to peers, licensed practical nurses, and ancillary nursing personnel, consistent with their levels of education and expertise, in order to meet client needs.	B. delegating aspects of care to other nursing personnel, consistent with their levels of education and expertise, in order to meet clients' needs and to maximize staff performance.
C. maintaining accountability for own care and care delegated to others to assure adherence to ethical and legal standards.	C. maintaining accountability for own care and care delegated to others to assure adherence to ethical and legal standards.
D. recognizing the need for referral and conferring with appropriate nursing personnel for assistance to promote continuity of care.	D. initiating referral to appropriate departments and agencies to provide services that promote continuity of care.
E. working with other health care personnel within the organizational structure to manage client care.	E. assuming a leadership role in health care management to improve client care.

APPENDIX D

A VALUES FRAMEWORK

Universal Values

Hall (1986) identified four major worldviews that are universal in nature: survival or security, interpersonal or belonging, autonomous, and interdependent. The stance people assume toward their environment at a particular moment is a concrete expression of their worldview and their level of value development. In a moment of reflective action they have ranked their values, engaged their meaning system, and activated their worldview. At every level of consciousness there is a central reference point around which experience is organized. This point is the response of the self to the environment; the self's valuing process.

Hall (1986), in his work for the International Values Institute, created an instrument based on the cultural research begun in Cuernavaca, Mexico with Paolo Friere, Ivan Illich, and Eric Fromm. Over a 20-year period the tool has been revised. Based on Hall's research findings, 125 value words that consistently appear throughout the life span of individuals and organizations have been identified in both written and spoken language. These value words or names have been reduced to 55 clusters of similar values. Within that context four worldviews (stages of value development) were identified (Hall, 1986, pp.10-14):

* World View 1- SURVIVING (Includes 20% of the entire population.)

Self as center..(SAFETY & SECURITY FOCI)

+ Power center is outside the self; the world is a mystery over which I have no control.
+ Needs are dominant in determining one's own behavior;
+ The perceived environment is filled with war and violence;
+ Meaning is acquired through satisfaction of the senses;
+ Choices are made based on self-preservation needs;
+ The self is innocent with marginal instrumental skills.

* World View 2-BELONGING/INTERPERSONAL (60% of the world population)

The world is seen as problem/Self as belonging... (FAMILY & INSTITUTION FOCI)

+ The world is enlarged to include social dimension;

+ Self-esteem is achieved by becoming useful;
+ Playing by the rules assures acceptance by others;
+ Meaning is experienced through working with and being approved by others;
+ Interpersonal skills are developing along with competence and adequacy, giving a sense of self-worth;
+ Choices are made based on social needs.

World View 1 and 2 are readily illustrated in American society, while Phase 3 and 4 are less visible.

* World View 3- SELF-INITIATING (16% of population, 2% of women)

World as project /Self as inventor...(VOCATION & NEW ORDER FOCI)
Focuses on independent decision making, trusting one's self, and one's vocation.

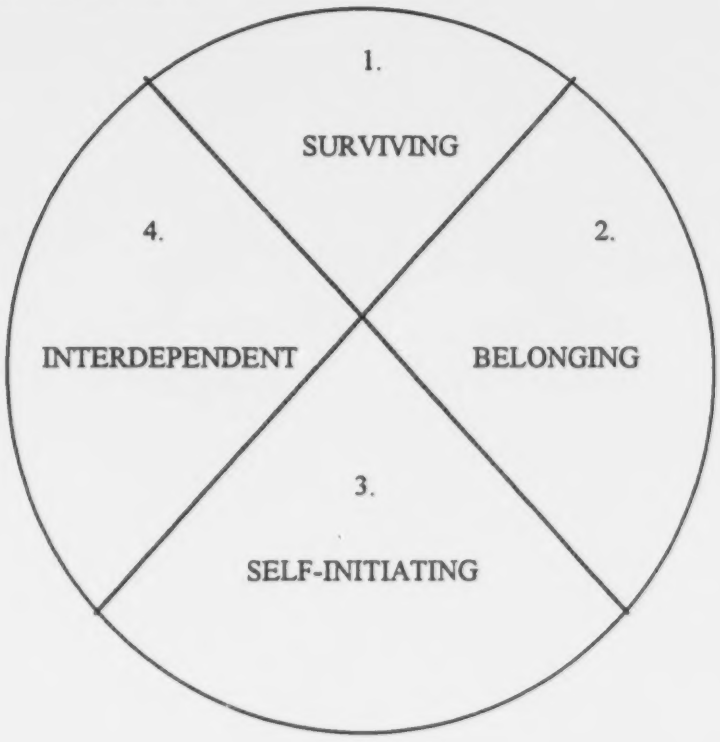
+ Internal and personal expectations replace external ones;
+ Personal power and authority replaces institutional control: the self begins to take charge;
+ Creativity and imagination are prized, giving rise to increasing imaginal skills;
+ A newfound sense of honesty makes conformity hypocritical;
+ Increased sensitivity to the rights of others leads to a concern for social justice-expanding the self into the larger society;
+ Meaning is present only as one listens to one's inner voice.

*World View 4- INTERDEPENDENT (4% of population, e.g. Mother Teresa)

World as mystery to be cared for/ Self as lifegiver...(WISDOM & WORLD ORDER FOCI)
There is a broader view of world order and the interconnectedness of self and others.

+ Complete transcendence of the self occurs;
+ Power is used to choose, create and enhance the world through cooperation in interdependent action;
+ Movement towards community focused on global transformation through a broad systems perspective;
+ Harmony and congruence are present in personal and global relationships;
+ Creative projects experience synergy, effects far exceeding the sum of individual efforts through the integration of new technology and interpersonal relations.

Figure 3. Hall's World Views



Values and their resultant worldview are learned. Socialization involves internalizing the assumptions, arbitrary typifications, and values taken for granted and communicated by significant others or from educational experiences. However, most of the knowledge acquired across the life span happens during (or as a consequence of) actual lived experiences. It is the feedback from community to the individual that validates the reflective act that prompts individual growth. The more complex and challenging the environment or life experience, the greater the development and predisposition to a higher level. The differentiating factor is how much initiative the individual exhibits in addressing the wants, needs, and motivations that create conflict and tension within his/her value structure. At higher levels of need complexity and value hierarchies, the self-actualized individual makes a conscious choice, from among real alternatives for personal advancement, to implement social change that will satisfy authentic needs.

Values, however, do not exist in isolation. Values are expressed in clusters, and it is these clusters or sets of values that can be used to differentiate various professional groups (Hall, 1986, p. 27):

Clergy	Engineers	Army Recruiters
Sharing/Listening /Trust	Economic Productivity	Rights/Respect
Worship/Faith/Creed	Adaptability/Flexibility	Duty/Obligation
Loyalty/Fidelity	Compensation/Knowledge	Responsibility

Social orientation and cultural norms within various professional disciplines influence group behavior as surely as family-of-origin culture and lifestyle influence individual value clusters and behavior.

Types of Values

Within the four broad world views Hall (1986) identified three types of values: goal, means, and motivation values. The worldview to which an individual or group belongs is determined by identifying clusters of these goal, means, and motivation values.

Goal values reflect the orientation of the individuals and the outcomes being sought in daily living. Examples of goal values include: self-competence/confidence, work/labor, and worship/faith/creed.

Means values are the attributes used to acquire goals, the framework for decisionmaking in daily affairs. Examples of Hall's means values are: sharing/listening/trust, responsibility, and adaptability/flexibility.

Motivation values are those that reflect the future vision an individual aspires to achieve. These values provide motivation and energy for continued growth and development. As current values are mastered and integrated into the self through education and experience, the individual will move to higher level motivation values. Motivation values include: collaboration/subsidarity, community/personalist, and intimacy as unitive.

Differentiated Nursing Values

Koerner (1993) demonstrated that there are differing value sets for nurses working in differentiated roles within the broader discipline of nursing. When nurses were tested using the Hall-Tonna instrument to identify which values had priority and how theses values clustered, some commonalities were identified and some unique differences were identified dependent upon the differentiated practice role. These value sets reflected differentiating values specific to each role category: associate nurse (AN) based on ADN competencies; primary nurse (PN) based on BSN compe-

tencies; advanced practice nurse (APN) based on MSN competencies; and leader based on PhD competencies.

Koerner's study (1993) demonstrated that there are shared values unifying all nurses, irrespective of their roles. The study further demonstrates, however, that nurses practicing within differentiated nursing roles reflect unique or different sets of goal, means, and motivation values.

Goal Values

Goal values reflect the orientation of the individuals and the outcomes being sought in daily living. The following goal values were consistently identified by all nurses, and represent part of the framework or shared values of the discipline.

Self-Competence/Confidence--belief in one's self and one's abilities--Worldview 2

Life/Self-Actualization--the inner drive towards experiencing and expressing the totality of one's being through spiritual, psychological, physical, and mental approaches to life that enhance the development of one's maximum potential--Worldview 3

Integration/Wholeness--The inner capacity to organize the personality (mind and body) into a coordinated, harmonious totality--Worldview 3.

Service/Vocation--To be motivated to use one's gifts and skills to contribute to society through society through one's occupation, business, profession, or calling-Worldview 3

Some significant differences in goal values, however, were found in other areas. ADNs and BSNs shared the selection of work/labor and worship/faith/creed (both in Worldview 2), while the MSNs and the PhDs selected faith/risk/vision, and knowledge/discovery/insight (Worldview 3) as high priority.

Goal Values of the ADN and BSN Roles

Work/Labor--having minimal skills and rights that allow one to produce a minimal living for oneself and family--Worldview 2 (Doing things right).

Worship/Faith/Creed--reverence and belief in God as expressed and experienced through a commitment to doctrines and teaching of a formal religious belief--Worldview 2 (this value is committed to policy, protocol, and an external locus of control orientation).

Goal Values of the MSN and Leader Roles

***Knowledge/Discovery/Insight**--the pursuit of truth through patterned investigation, which is motivated by increased intuition and unconsciously gained understanding of wholeness of reality*--Worldview 3 (Doing the right thing).

***Faith/Risk/Vision**--behavioral commitment to values that are considered life-giving even at risk to one's own life*--Worldview 3 (this value is committed to co-creation via one's own initiative and autonomy, an internal locus of control orientation).

The MSNs and the leaders demonstrated a greater orientation into Worldview 3 - with a greater focus on autonomy in the goal values that reflect outcomes being sought in daily living.

Means Values

Means values are the attributes used to acquire goals, the framework for decisionmaking in daily affairs. All nurses selected Sharing/Listening/Trust, Generosity/Service, Personal Authority/Honesty, and Productivity as high priority means values.

Means Values of All Nurses

***Sharing/Listening/Trust**--The capacity to actively and accurately hear another's thoughts and feelings and to express one's own thoughts and feelings in a climate of mutual confidence in each other's integrity*--Worldview 3.

Generosity/Service--To share one's unique gifts and skills with others as a way of serving humanity without expecting reciprocation--Worldview 3.

***Personal Authority/Honesty**--The freedom to experience and express one's full range of feelings and thoughts in a straightforward manner, as a result of personal integration of thoughts and feelings resulting in experiencing one's own integrity and power*--Worldview 3.

***Productivity**--To feel energized by generating and completing tasks and activities and achieving externally established goals and expectations*--Worldview 2.

Unique Means Values of the ADN Role

ADN's selected Responsibility as a high priority means values. They are also the only group to identify obedience within the top ten values selected.

***Responsibility**--Being personally accountable for and in charge of a specific area or course of action in one's organization or group*--Worldview 2.

Means Values of the BSN Role

***Rights/Respect**--The moral principle of esteeming the worth of another as I expect others to esteem me*--Worldview 2.

Means Values of the MSN Role

***Growth/Expansion**--The ability to enhance an organization to develop and grow creatively. This assumes skills in management design and organizational development at a corporate level*--Worldview 3.

***Adaptability/Flexibility**--To adjust oneself readily to changing conditions and to remain viable during ongoing change*--Worldview 3.

Means Values of the Leader Role

***Creativity/Ideation**--Capacity for original thought and expression that brings on a formal body of information. The capacity to exercise reason before emotion*--Worldview 3.

***Pioneer/Innovation/Progress**--Introducing and originating creative ideas for positive change in social organizations and systems and providing the framework for actualizing them*-- Worldview 3.

***Interdependence**--Seeing and acting on the awareness that personal and interinstitutional cooperation are always preferable to individual decision-making*--Worldview 4.

Motivation Values

Motivation values are those that reflect the future vision an individual aspires to achieve. These values provide motivation and energy for continued growth and development. As current values are mastered and integrated into the self through education and experience, the individual will move to higher level motivation values. The motivation values found uniquely in each role cohort predicted the differentiated role choice made by each nurse.

Motivation Values of the ADN Role

The ADN role encompasses the traditional registered nurse role at the bedside. This nurse provides care to the client for a specified shift of service, focusing on care, comfort, and physiological stabilization. The one motivational value unique to this role is:

***Intimacy as Unitive**--The experience of personal harmony from mutual openness and total acceptance of another person which leads to new levels of meaning and awareness*--Worldview 4.

Motivation Values of the BSN Role

The BSN role carries 24-hour accountability and is responsible for the integration of medical and nursing orders to facilitate timely discharge for a well-prepared client. This nurse may also provide care in the community if the client needs skilled nursing care in the home. The unique motivational value for this nurse cohort is:

> ***Collaboration/Subsidarity***--*The ability of an organizational leader to cooperate interdependently with all levels of management to ensure full and appropriate delegation of responsibility*-- Worldview 3.

Motivation Values of the MSN Role

The MSN role is accountable for staff development, research and case management of specific clients across the continuum of care for the duration of the illness or the lifetime of the client. The motivational value unique to this role is:

> ***Community/Personalist***--*Sufficient depth and quality of commitment to a group, its members and its purpose so that both independent creativity and inter-dependent cooperation are maximized simultaneously*--Worldview 4.

Motivation Values of the Leader Role

The motivation value unique to the Leader role is:

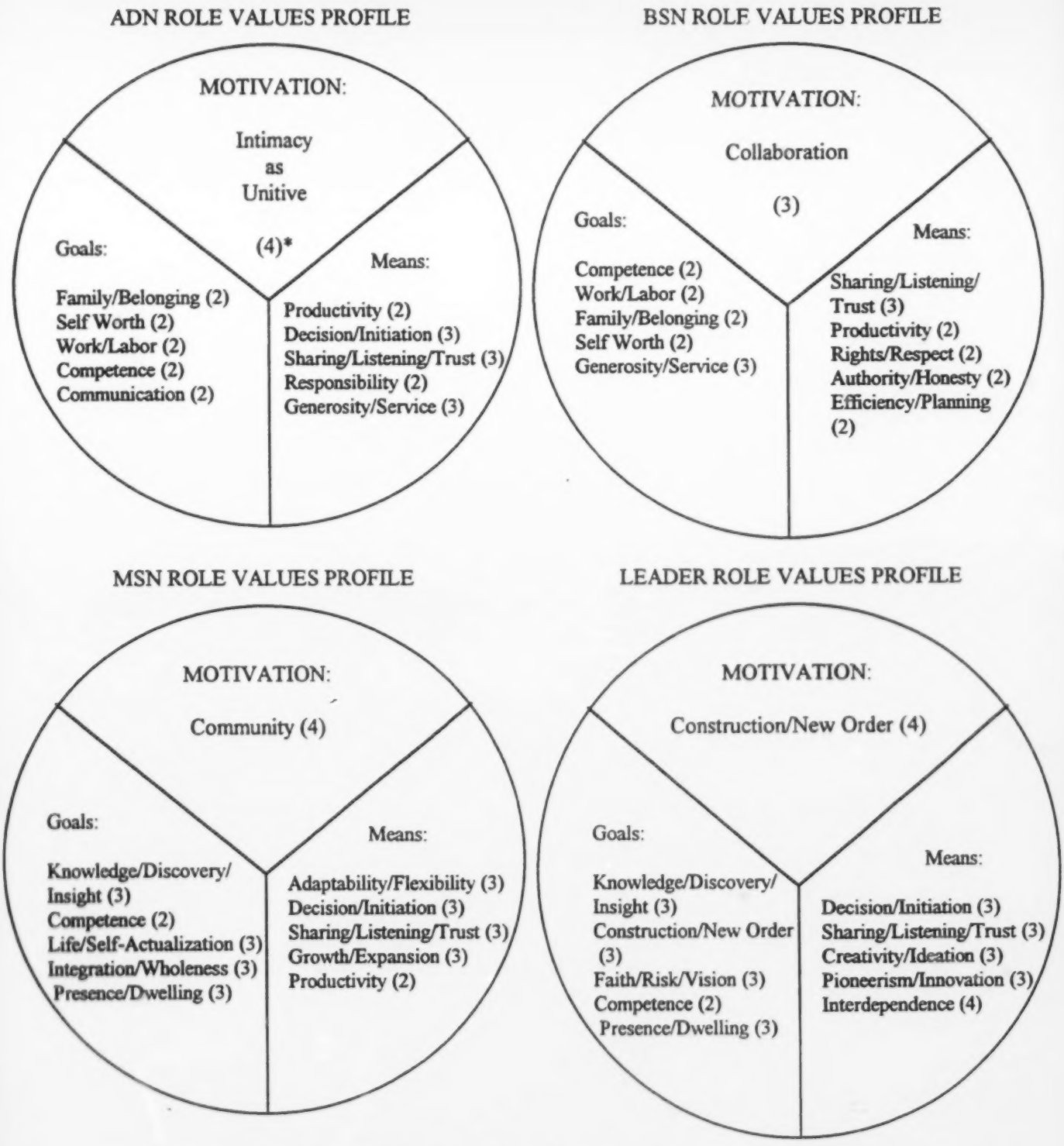
> ***Construction/New Order***--*To develop and initiate a new institution for the purpose of creatively enhancing society. This assumes technological, interpersonal and management skills--Worldview 4*

Values Profiles of the Differentiated Nursing Roles

By examining each nursing role, profiles shown in Figure 4 for each differentiated nursing role were identified (Koerner, 1993).

Analysis of the aggregate values profiles of each group shows that when all 55 value clusters are combined, each group demonstrates a different stage of worldview development. ADN prepared nurses have a value base that falls primarily within Worldview 2 - Belonging or Interpersonal Focus. BSN prepared nurses demonstrate a core set of values that overlap Worldview 2-Belonging/Interpersonal and Worldview 3-Autonomy or Self-Initiating. MSN prepared nurses function within the Autonomy value base and leaders in nursing in the high end of Autonomy values. Nurses prepared with advanced degrees also reflect a larger number of values that fall into

Figure 4. Value Sets of Differentiated Nursing Roles



* Number in parentheses indicates in which worldview value exists.

Worldview 4 - Interdependence. Where the differentiated nursing roles fall within Hall's four worldviews are shown in Figure 5.

The worldview in which each of the nursing roles primarily falls is reflected in the relationships and roles exemplified by differentiated nursing practice. One example of this role differentiation is: the ADN has a primary relationship with the client, while the BSN collaborates and interconnects the work of the health care team. The MSN prepared nurse relates across the continuum of care with multiple agencies and provider groups while Leaders in nursing focus on improving the relationships of society as a collective.

Teaching Core Values

An awareness of basic skill sets associated with various values needed for transformative and healing work can help us arrange things more holistically. Hall (1986) identified four major skill sets essential to fostering the development of complex values:

INSTRUMENTAL SKILLS (Core to Worldview 1 - Surviving): These must be acquired before any other skills can be accomplished. They represent a blend of physical and intellectual skills:

* Coordinates oneself physically
* Read, write, and handle numbers
* Speak clearly and effectively
* Think logically
* Make and manage budgets and other schedules
* Manage time efficiently
* Use tools and technology
* Dexterity in job-related tasks

INTERPERSONAL SKILLS (Core to Worldview 2 - Belonging): One must learn to perceive self and others accurately; communicate in a manner that facilitates trust, understanding, cooperation, and intimacy:

* Identify own feelings accurately
* Identify others' feelings accurately
* Express positive and negative feelings openly, appropriately
* Empathize, enter another's world
* Experience others behavior non-judgmentally
* Cope with conflict productively

Hall's System of VALUES FOR MISSION

Phase I SURVIVING	Phase II BELONGING	Phase III SELF INITIATING	Phase IV INTERDEPENDENT
The world is a mystery over which I have no control.	The world is a problem with which I must cope.	The world is a project in which I want to participate.	The world is a mystery for which we care on a global scale.
The world is a mystery over which I have no control.	The world is a problem with which I must cope.	The world is a project in which I want to participate.	The world is a mystery for which we care on a global scale.
DICTATORIAL Tyrant dictator with oppressed followers who are totally dependent.	**BENEVOLENT** Benevolent paternalistic with followers who are dependent and obedient.	**MANAGER** Efficient manager with followers who are loyally devoted to the organization.	**ENABLING** Clarifier, supporter and listener with followers who are also clarifiers, listeners and supporters.	**COLLABORATOR** Facilitator, producer, creator with intermediate peer participation.	**SERVANT** Interdependent administrators with collegial participation.	**VISIONARY** Liberator with a global network of peer visionaries.
(Self) Interest/Control (Self) Preservation Wonder/Awe/Fate	Physical Delight Security	Family/Belonging Fantasy/Play (Self)Worth	(Self)Competence/ Confidence Play/Recreation Work/Labor Worship/Faith/Creed	Equality/Liberation Integration/Wholeness Life/Self/Actualization Service/Vocation	Art/Beauty/Pure Value Being Self Construction/New Order Contemplation/ Asceticism Faith/Risk/Vision Human Dignity Justice/Social Order Knowledge/Discovery/ Insight Presence/Dwelling Ritual/Communication	Intimacy & Solitude as Unitive Truth/Wisdom/ Integrated/Insight	Ecority/Aesthetics Transcendence/Global Equality Word
Food/Warmth/Shelter Function/Physical Safety/Survival	Affection/Physical Economics/Profit Property/Control Sensory/Pleasure/ Sexuality Territory/Security Wonder/Curiosity/ Nature	Being Liked Care/Nurture Control/Order/ Discipline Courtesy/Hospitality Dexterity/Coordination Endurance/Patience Equilibrium Friendship/Belonging Obedience/Duty Prestige/Image Rights/Respect Social/Affirmation Support Peer Tradition	Achievement/Success Administration/Control Communication/ Information Competition Criteria/Rationality Design/Pattern/Order Duty/Obligation Economics/Success Education/Certification Efficiency/Planning Hierarchy/Propriety/ Order Honor Law/Rule Loyalty/Fidelity Management Membership/Institution Ownership Patriotism/Esteem Productivity Responsibility Rule/Accountability Technology/Science Unity/Uniformity Workmanship/Art/ Craft	Adaptability/Flexibility (Self)Assertion/ Directness Congruence Decision/Initiation Empathy Equality/Rights Evaluation/Self System Expressiveness/ Freedom/Joy Generosity/Service Health/Healing/ Harmony Independence Law-Guide Limitation/Acceptance Obedience/Mutual Accountability Personal Authority/ Honesty Relaxation Search/Meaning/Hope Sharing/Listening/ Trust	Accountability/Ethics Collaboration/ Subsidiarity Community/Supportive Cooperation/ Complimentarity Corporation/New Order Creativity/Ideation Detachment/Solitude Discernment/ Communal Education/Knowledge/ Insight Growth/Expansion Intimacy Leisure/Freesence Limitation/Celebration Mission/Objectives Mutual Responsibility/ Accountability Pioneerism/Innovation Progress Research/Originality Knowledge Simplicity/Play Unity/Diversity	Community/Personalist Detachment/ Transcendence Interdependence Prophet/Vision Synergy	Convivial Technology Human Rights/World Social Order Justice/Global Distribution Macroeconomics/ World Order Minessence Word

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55

C. Brian P. Hall, 1990

Figure 5

← ADN →
← BSN →
← MSN →
← Leader →

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* Give and receive feedback non-defensively

IMAGINAL SKILLS (Core to Worldview 3 - Autonomy): To see new possibilities one must learn to blend internal fantasy and feelings to contribute to the external world in new ways:

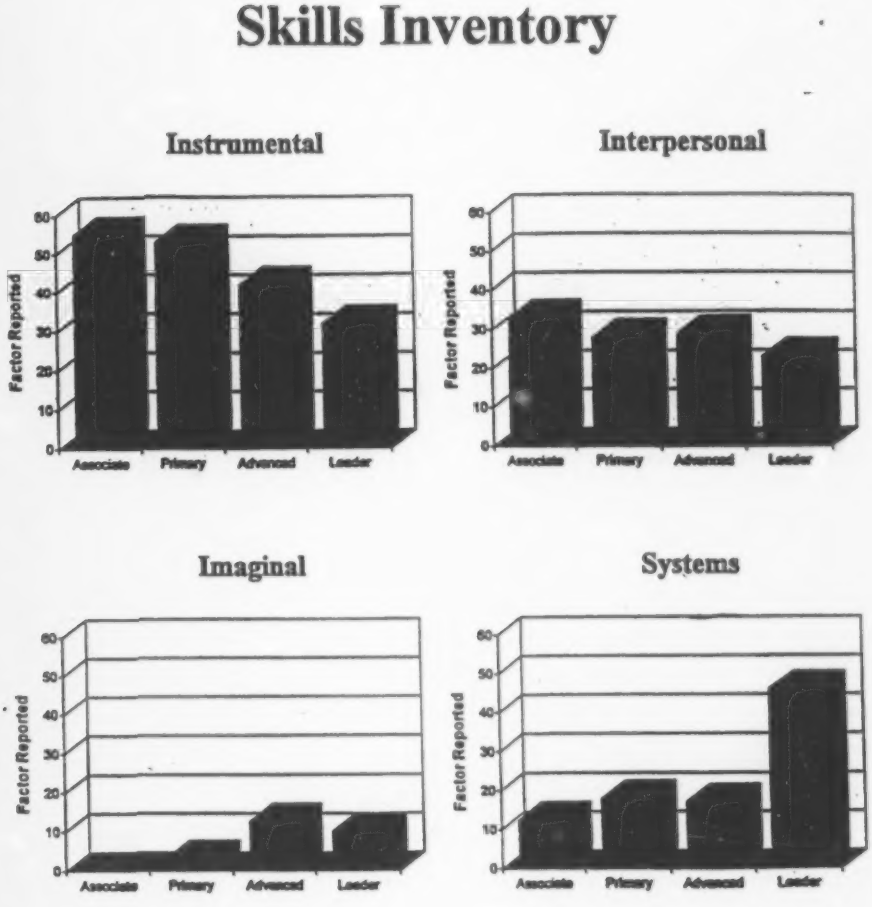
* Tolerate ambiguity
* Play with problems--see new angles
* See connection between unrelated events
* Put data together in new ways
* Dream new visions
* Use brainstorming techniques
* Participate in the essence of dialogue, poetry, drama, and the visual arts

SYSTEMS SKILLS (Core to Worldview 4 - Interdependence): Comprehend the interrelatedness of all things by grasping whole-part relationships:

* Ability to foresee and handle obstacles and opposition
* Read the signs of the times for self and system
* Motivate self and others to achieve a system goal
* Accurately assess strong and weak points of a system
* Determine realistic goals for self and system
* Distinguish between myth and reality of the system
* Enhance personal meaning from being part of the system

The Skills Inventory (Koerner, 1993), shown in Figure 6, shows a clear differentiation among the nursing roles and the acquisition of skills necessary to function within each Worldview. Hall (1986, pp.67-70) suggested that teachers identify a pattern of values at the appropriate developmental level for the student and use the language in the values to create their course content. The educator should then identify the skills (instrumental, interpersonal, imaginal or systems) related to the values and include the teaching of these skills in the curriculum design. For example, 1) BSN- and MSN-prepared nurses must be prepared to deal with ambiguity and change in patient care situations and in the larger health care delivery system and 2) opportunities to acquire the Interpersonal Skills must be incorporated into every nursing curriculum as they are foundational to the development of Imaginal and Systems Skills. It is by learning to understand one's self and to be understood by others that individuals are able to move into Worldviews 3 and 4. The patient care settings or context in which the Interpersonal Skills are taught and applied are what differ from one role to another.

Figure 6. **Skills Inventory**



APPENDIX E

TIME/SPACE ORIENTATION

The temporal (time) dimension of consciousness covers the way a person is mentally in touch with the past, present and future, and how these are present in the individual's worldview. The *past* represents experiences that are forever fixed in memory. It is viewed by the individual in two dimensions: rationally the way it is comprehended, and emotionally with celebration or guilt. The *present* domain represents an awareness of what is, one's current reality. Comprehension of reality rationally determines one's perception of the event. Emotionally the individual may accept the reality as she or he has defined it, or may experience fear or frustration. The *future* exists in one's imagination. It is an unfixed sense of anticipation that is always in process, always incomplete. The primary emotions aroused include anxiety, fear, and hope.

Emotional attitudes toward the future differ depending on each person's level of consciousness, which encompasses more than intellectual ability or IQ. Fear and anxiety connote mental impoverishment, the opposite of hope and enthusiasm needed for the creative imagination of a well-developed consciousness. Creative dreaming differs from aimless dreaming because it integrates the limitations of the present situation and structures into alternative future scenarios. To be able to choose and design one's own world is the process of making-meaning. This evolves from the combined synergy of an expanded consciousness and well-developed set of imaginal and systems skills.

The dimension of space also plays a significant role in consciousness development. The life space of an individual (his/her world of reality) is comprised of insignificant and significant space. Insignificant space does not concern or interest a person. It is where one does not operate mentally or physically, it is not a theater for personal action. Significant space is the field of consciousness and action. It tends to expand as one grows and is comprised of all that one knows through acquisition of knowledge and the lived experience. Sacred space is particularly important as it is the environment that is structured to help people make sense of their lives, to make choices that lead in growth toward an enlarged level of consciousness. It is in this reflective space that discernment is attained.

Healthy individuals demonstrate a balance in their use of time between work and play. The study done by Koerner (1993) also examined the time component of the various nursing roles based on the relationship of values to time. Use of time was designated to four categories:

* *Work* - the time spent on prescribed duty-oriented tasks necessary for vocation and life orientation, i.e., working at the office and connecting with mother to support her.
* *Maintenance* -the time spent coping and maintaining oneself and others. It is maintaining property, and maintaining one's job, i.e., shopping for groceries, repairing the car.
* *Play* - the time spent relaxing and being oneself outside of any duty-related activity. It takes few skills but is recreational. It is the beginning of the process of detachment, i.e., listening to music, taking a walk.
* *Reflective Self* - the time spent reflecting that takes as many skills as one's vocational endeavors. It is contemplative leisure that enables one to be most authentic, creative and alive, i.e., writing a poem, playing a Bach fugue, contemplating a philosophical question, etc.

The value analysis identified the most likely inclination toward time, based on individual response to the research tool for each of the four nursing roles. Time management and a playful approach to life are essential to the fostering of contemplation and creativity. This mindset is critical to facilitation of flexibility and adaptability in a rapidly changing world.

The time/space orientation of the differentiated nursing practice roles vary. ADN nurses work within a time frame that is present based; BSN nurses focus on the present as a means for achieving future outcomes (Koerner, 1993). These differences are evident in the differentiated practice models currently being implemented by the Healing Web Project. The ADN nurse works within clearly defined paths and works from a base of the norm or usual illness experience with predicted outcomes regardless of the care setting. The BSN nurse is able to assimilate the present, the norm, and significant variation within a plan for intervention. By doing this he or she provides care across settings in which outcomes are more ambiguous and in situations that require the utilization of more complex data and coordination of more extensive resource application. The MSN nurse brings the broader view, which includes the use of various systems' components for highly complex, ongoing client situations across settings and the life span.

APPENDIX F

DIFFERENTIATED NURSING PRACTICE /PATIENT CARE EXEMPLARS

Marcella's Story

by
Jill DeVries, RN, Primary Nurse
Nancy Foss, RN, Advanced Practice Nurse
Kris Seanor, RN, Associate Nurse

as recorded by
Kathryn Karpiuk, RN, BSN, MNE

The Pulmonary/Renal Unit at Sioux Valley Hospital, Sioux Falls, South Dakota, has 30 beds with primarily chronically ill patients. There are 3 primary nurses (PN), based on bachelor's of science in nursing (BSN) competencies; 30 associate nurses (AN), based on associate degree in nursing (ADN) competencies; and a part-time advanced practice nurse (APN).

Marcella is a 59-year-old, married woman. She has 9 children, but her primary support person is her husband, who is a minister. The children seldom visit during her hospitalizations. She is very active in her church and community. During the last few years she has been admitted frequently to Sioux Valley Hospital. Jill, a BSN-prepared nurse, became acquainted with her about 5 years ago when Marcella first came to Sioux Valley Hospital.

Marcella has chronic obstructive pulmonary disease and retains carbon dioxide; she is a former smoker. She is a large woman and has obstructive sleep apnea. She has cor pulmonale, is a non-insulin dependent diabetic, and has a history of peptic ulcer disease, remote seizures, hypertension and congestive heart failure.

When Marcella enters the hospital, she likes to have control over her care. She is very knowledge-able about her lung disease and its management. Early in her health care treatment at Sioux Valley Hospital, her compliance with smoking cessation was questioned. She continued to smoke even

though she understood that smoking was harmful. This lifestyle change was extremely difficult for her.

She has a good support system at home, particularly from her husband. She has been asked on other admissions if she would like the assistance of a visiting nurse at home. This offer always has been refused, and she has stated that she could rely on her friends in the community and parishioners for assistance if necessary.

Marcella's need for control over her care is very important to her. This need was a major factor in the development of the relationship between Jill, the BSN-prepared nurse, and Marcella. Becoming trusted by the patient was an important first step in the plan of care developed by Jill. In order to develop this trust Jill assumed responsibility for some of the "doing" aspects of Marcella's care. Often patients think the "primary" or BSN nurse is a social worker or dietitian because of the nature of the interactions and teaching. When Jill first got to know Marcella, the BSN nurse role was not clear to Marcella. Eventually the differentiated practice roles became clear and the BSN nurse was sought by Marcella appropriately. All of the RN roles were eventually valued and understood by Marcella and she called on the appropriate role when help was needed. Jill facilitated the establishment of a schedule that helped fulfill Marcella's need for control. Nap times, physical therapy, respiratory therapy, and even her PRN medications were scheduled.

The need for daily continuity in her care by the associate degree nurses (ADNs) and the physicians was also important to Marcella. There are five pulmonologists who rotate on the unit so Marcella might have a different physician assigned to her care on each admission. Communicating her history, wishes, and concerns was important for continuity from one admission to another. One example of the importance of continuity was that, despite Marcella's extensive medical history, she desired to be a full "code" and expressed some resentment toward physicians when this issue was raised. The primary nurse communicated Marcella's wishes to the physicians and the rest of the health care team so that continuity was maintained.

At Sioux Valley Hospital, primary nurses work 8-hour shifts, 5 days per week, and the associate nurses work 12-hour shifts, 3 days per week. The primary nurse, therefore, is there on a day-to-day basis for patient communication and continuity.

Marcella's Most Recent Admission

Nancy, the advanced practice nurse, had become familiar with Marcella on previous admissions because of the chronicity of her condition and her frequent admissions; therefore, Nancy knew Marcella quite well prior to this admission. Marcella was admitted through the emergency room (ER) in acute respiratory failure. She was immediately intubated and sent to the intensive care unit (ICU). Nancy was notified of Marcella's admission and consulted concerning her care because the primary nurses in the ICU were not familiar with Marcella. Nancy developed a plan of care by working with the nurses and physicians in the ICU.

Marcella's stay in the ICU became quite difficult. She was weaned off the respirator once and had to be reintubated. The possibility of long-term ventilation and a tracheostomy was discussed. During this time Nancy acted as a liaison between the physicians, staff, and the family. She worked with Marcella and her husband to make this very difficult decision. Eventually they did decide to proceed with the tracheostomy and to pursue plans for long-term ventilation. Once Marcella was stabilized, she was transferred to the pulmonary unit. Nancy, the APN, continued to follow her and coordinate all aspects of her health care.

Kris, the associate degree nurse (ADN) is responsible for the patient's daily care. Marcella is very independent and likes to maintain a very strict schedule. Due to a 3-day work week, several ANs provided her care. Jill, the primary nurse, provided the continuity through the plan of care. Some parts of Marcella's schedule were: Marcella wanted her Ativan one-half hour before coming off the ventilator, as well as other pills at specified times; after her medication she wanted her blood sugar checked; following her bath at a certain time, the ADN did her tracheostomy care for which the primary nurse had developed an individualized care and teaching plan.

Marcella and her husband required a great deal of teaching in order to prepare her for independent living in her own home. Her respiratory status made it necessary for her to be transferred temporarily to a subacute care unit in a long-term care facility. The primary nurse and associate nurses provided support to her and her husband throughout this difficult decision-making process. Marcella valued her independence and did not want to live in a nursing home or long-term care facility.

If a problem arose in the daily delivery of her care, or if Marcella or one of the associate nurses had questions or concerns, they called on Jill, the primary nurse. Marcella valued Kris' competence because Kris, as an AN, knew how to take care of Marcella's daily needs. She believed Kris understood her goals and her emotional needs, especially when she was anxious. Marcella

also valued the relationship Kris and the other associate nurses had with her and said that "Kris knew her stuff."

The respiratory therapists also were very involved in Marcella's care because of the ventilator and tracheostomy. They were able to provide answers to her questions particularly about the ventilator. They also provided consultation to the nursing staff. Marcella was difficult to wean and occasionally had to be put back on the ventilator for short periods of time, so that a close relationship between the nurses and respiratory therapists was necessary to provide optimal health care.

BSN and ADN students participating in the Healing Web Project were also assigned to provide care to Marcella. Marcella actually taught the students because she was so knowledgeable about her disease process and her self-care needs. It was an invaluable experience for the students to have a patient who knew how to care for herself and was able to deal with her chronic health state.

Due to Marcella's frequent admissions to the pulmonary unit and even more frequent visits to the emergency room (ER), there was a demanding need to look at cost-containment. Nancy and Jill coordinated a care conference with ER staff, physicians, and Marcella so that needs and expectations could be clarified and a plan of care developed. This conference was held partially in response to Marcella's need for control, but also to provide continuity beyond this one admission.

Marcella's eventual goal was to return home, but her health status necessitated a transition period from acute care back to the home. Marcella had to make a big adjustment when it became evident that her medical condition necessitated long-term care placement. In preparing for the long-term care facility, Marcella wanted to know absolutely everything about the facility. Staff from the long-term care facility visited with Marcella in the hospital. Nancy and Jill had a pre-placement care conference with the staff to discuss her care, her history, needs, and goals. Mutual goals were established with Marcella and the staff. Marcella wanted to know not just what the goals were but how they would be implemented once she was transferred out of the hospital. The staff, therefore, needed to understand the goals and plan of care.

A target date was set for transfer from the acute care to the subacute care setting. The hospital was ready to discharge her, the subacute unit was ready to accept her, and Marcella was ready to go. Insurance negotiation problems arose, however. Because she is not of Medicare age, a private insurance company was responsible for the coverage of her care. Few ventilator patients

had been admitted to the subacute unit, therefore, the staff were inexperienced in dealing with insurance contracts in this situation. The APN assumed responsibility for the negotiations and interventions necessary in making the arrangements to facilitate the process.

Nancy, the APN, collected cost information for comparison of charges. Marcella was hospitalized for 43 days with an average charge per day of $1,800, which included the first days in the ICU. By transferring her to the subacute care unit in the long-term care facility, the cost per day was decreased to approximately $950. By sending her to the long-term care facility for the interim period until she was able to return home, a total of $28,000, a conservative estimate, was saved. The cost of home care averages $54 per day, a cost that includes a visiting nurse, a visiting nursing assistant, and durable medical equipment, including ventilator, oxygen, and nebulizer machine.

Nancy also served as a clinical resource for the long-term care staff. Nancy assisted with the difficult tracheostomy changes and with the discharge planning. The long-term care staff were not experienced in transferring such a complex patient back into the home. Nancy assisted them in procuring the necessary resources, such as visiting nurses and durable medical equipment. Everyone wanted the transition from the subacute unit to the home to be as smooth as the transition from the hospital to the subacute unit. To facilitate the transfer there was much collaboration among the various disciplines caring for Marcella including physicians, nursing home staff, and physical, occupational, and respiratory therapists. An extensive team cared for her, but Marcella was always the leader of that team!

Once Marcella was home, Nancy, continued to monitor her. Marcella continues to see Nancy in the clinic twice each month. Nancy does the tracheostomy changes and assesses her home maintenance making sure that the home environment is satisfactory and that she is doing well. She also coordinates the care provided to Marcella by the visiting nurse and visiting nursing assistant at home.

Having returned to her home environment, Marcella is again very involved in her church and her community, as she predicted six months ago. She is thriving, despite her extensive health history, and the tracheostomy tube that requires night-time ventilatory assistance. Nancy and the physician alternate seeing Marcella in the clinic setting; therefore, they are able to collaborate on her health care needs. Because Nancy sees her in the clinic, she can share Marcella's status with the pulmonary unit nursing staff. Because of her complex and chronic health care condition, she will be readmitted to the hospital at some point in the future, but because of her coordinated health

care, her admissions and use of the emergency room have been reduced dramatically and her length of stay in the acute care setting has been decreased.

Summary of the Differentiated Nursing Roles

During her shift of responsibility, Kris' role as an associate nurse comprised primarily the patient's daily care as well as interacting with the patient. She also assisted in teaching Marcella how to cope with her situation, prepared her to go home, and prepared her for the changes that would occur in her life, such as living with the tracheostomy and the ventilator.

Jill, the BSN or primary nurse, was responsible for collaboration with the patient, physicians, family, other resource people, and ancillary departments such as respiratory therapy and physical therapy. She was also involved in providing some of the more complex aspects of the daily care necessary particularly when initially establishing a relationship with the patient.

The mutual valuing among the differentiated practice roles of the associate nurse, the advanced practice nurse, and the primary nurse is also evident in the patient's valuing of each of the roles. The mutual valuing by the individual nurses and patient enhances the effort to provide holistic patient care. It is not just clinical tasks that must be done, but also the emotional, social and discharge needs of the patient that are of extreme importance. Much time is spent by the primary nurse meeting patients' discharge needs and collaborating with other resource people. Jill truly values the clinical expertise of the associate degree nurse, and also values the follow-up care and clinical expertise that the advanced practice nurse provides.

The luxury of the APN's role is that she/he can move from one unit to another within the hospital, go into the home or to the nursing home, and follow the patient in the out-patient setting or the clinic. The APN is able to follow the patient through all of the various health care phases and provide comprehensive and current information to the appropriate staff. This APN role provides continuity to the patient's care, which improves the quality and decreases the cost of long-term health care particularly of chronically ill patients and those with multiple health care needs.

Paul's Story

by
Sally Hefti, RN, Primary Nurse
Lenore Gentry, RN, Associate Nurse

as recorded by
Boni Deckert, RN, BA

Sally Hefti, RN, a nurse working in the primary nurse (or BSN) role, was introduced to Paul three weeks prior to his transfer to the rehabilitation unit at Lutheran Hospital-LaCrosse. Sally phoned the primary nurse on the burn unit in Madison, Wisconsin to obtain initial information in a nurse-to-nurse report. Immediate needs were identified and preparation was begun for his arrival at Lutheran Hospital. Sally selected two associate nurses (ANs) to work with Paul to assure his required continuity of care.

Paul arrived at Lutheran Hospital after a two and one-half month stay in the burn unit. This 33-year-old man had been injured at his job site while cleaning the floor with acetone, which ignited, causing second- and third-degree burns over 85 percent of his body. Paul wept upon his arrival at Lutheran Hospital where he was met by his father, brother, several sisters, his wife of five months, and her 3-year-old daughter, Erica, who referred to Paul as "Daddy."

Sally coordinated an admission assessment upon Paul's arrival at Lutheran. The multidisciplinary assessment was done by the team that would be caring for Paul: Sally, his primary nurse; Lenore Gentry and Peggy Laustrup, his associate nurses; a physical therapist; and an occupational therapist. The purpose of this approach was to introduce Paul to the team, to assist him with understanding the rehabilitation team concept of care, and to minimize the time and redundancy of the admission process. Sally, the primary nurse, began to assess Paul's functional health patterns upon admission and continued the assessment on an ongoing basis. This ongoing functional assessment was benefited by the assistance of his wife, Diane, and information from other family members.

Paul had been an active, virile adult with no prior health problems and therefore was a stranger to his new status of total dependence on others to meet his needs. He had worked at a local factory and had led a full and busy life that recently had centered around Diane and Erica. Lenore, the associate nurse, noted that in addition to his burns, Paul had tested positive for MRSA

(Methicillin Resistant Staph Aureus), necessitating the use of MRSA Isolation Precautions, which included the use of gowns, gloves, and masks for direct patient care. The fifth finger on his left hand had been amputated due to necrotic burns. His other burns had been treated with skin grafts from both cadaver and his own body donor sites.

Lenore and Peggy began the care planning process with Paul by instituting the established standards of care for burns and for acute pain. They skillfully monitored fluid intake, integrity and quantity of urinary output, specific gravity, circulatory status, GI function, and respiratory status. They helped Paul to turn, to cough, and to deep-breathe, and they monitored the need for incentive spirometry. Range-of-motion in the affected extremities was documented and compared to Paul's norms. Massage therapy was done with gentle pressure, gauze and ace wraps were used, and the signs and symptoms of infection were carefully assessed and taught to him and his family. Signs of healing were monitored and documented. Paul was positioned carefully to prevent contracture formation. Pillows, blankets, braces, and boots were placed and removed while pain and comfort were assessed and analgesia provided as necessary. Diversion, rest, relaxation, and hope also were pursued extensively.

Lenore incorporated the protocol for MRSA precautions into his personal care routine, along with a daily schedule for washing his wraps, Jobst body suit, and braces. Sally, the primary nurse, completed the care plan by adding the nursing diagnosis-based components to individualize Paul's care. Her analysis of his functional health patterns led to three diagnoses: 1) powerlessness due to loss of function and control in his life; manifested by verbalization and crying; 2) disturbed self concept due to his sudden change in appearance; and 3) alteration in skin integrity due to the burns over 85% of his body.

Within the first two days of Paul's stay on the rehabilitation unit, Sally, the primary nurse, and Paul wrote mutually agreed upon long-term goals: to be independent in his functional activities; to be able to ambulate the 16 steps up to his apartment by discharge; to require minimal assistance with all skin cares. The care plan was put into place and followed on a shift-to-shift, hour-by-hour basis by the associate nurses providing his daily care.

As Lenore cared for Paul during her 8-hour shift, she found herself guarding her own feelings as she viewed the layers of skin and visible fat on his chest wall. She was grateful that his face had escaped the searing heat and was not burned. In isolation garb, she was too warm when Paul was too cold. Yet her mask, hat, and gown allowed her to mask her emotions when she wanted to cry with Paul and when she, alternately, wanted to cry with Diane. She understood Paul's disturbed

feelings about his self concept. Initially, her work with Paul was emotionally demanding as well as fatiguing. Sally's plan to assign two associate nurses to Paul had been insightful, both to promote continuity of care for Paul and to prevent burnout of the nurses.

Lenore described Paul as "flat as a board," experiencing a great deal of pain from the therapy and the stretching. Her shift-to-shift goals often centered around grooming and behavior modification that would turn tears and manipulation into steps toward independence and self worth. His bowel and bladder needs were an ongoing problem. Skin care needs were ever-changing. Blisters, tears, and abrasions demanded continuous care. Convincing Paul to keep the splints on was a daily challenge.

The 6'7" Paul wore a purple Jobst body suit 24 hours a day. Coupled with the staff, gowned in blue and looking very short, this rehabilitation team soon became known as "The Smurfs." Paul's feelings of isolation and sense of being different began to lighten in the midst of the "Smurf Team."

The communication among Sally and the associate nurses was very important due to the complexity of the case. Sally was constantly communicating with all disciplines involved with Paul's care: physical therapy, occupational therapy, neuropsychiatry, nutrition services, pastoral care, and therapeutic recreation. She continually updated the plan of care and changed the strategy as the need arose.

As Paul became more functional, the focus of Sally's nursing orders needed to progressively change to assist Paul in becoming independent with the activities of daily living. He had become a very needy person and the goal of functional independence was a challenge like none he had ever faced before. Paul's emotional needs were as great as his physical needs. A behavioral guideline headed by the neuropsychologist gave direction to Paul's team. Tasks completed were rewarded with free time outside.

Paul likened the work differentiation at the hospital to the work roles at his factory. He saw Sally as the foreman who made sure that his care was being done according to plan. He felt that if he had a "big" problem, she would be the person to solve it. Other staff came in to work their shifts. Paul asked for more one-on-one time with his "foreman," and Sally included a half hour of her time scheduled into his day. Paul could decide what he wanted to do with this time. He was in control of this part of his day. At times he wanted to talk, to plan for his future; other times he would cry, or just allow Sally to be there and to provide an accepting presence.

Paul's wife, Diane, was having trouble seeing the man she had married in his present burned, MRSA-positive body. It was difficult for Diane to touch Paul; she was afraid of the MRSA precautions. Sally asked her to bring the videotape of their wedding to the hospital. The primary nurse, associate nurses, Paul, and Diane, watched it together. Although an emotional time, it was the turning point for Paul and Diane. It helped both of them to see beyond the physical dimension of life and to get in touch with their hearts. Diane has since been involved in several teaching days and is now an active participant in the skin care and activities of daily living.

Today Paul, Diane, and Erica are looking forward to discharge. Diane has been advised of the community services available to them; Sally is checking into funding options for enclosing the outside staircase to their apartment. Contacts have been made with the public health nurse and a home health agency. Ongoing education days have been scheduled for Diane on the rehabilitation unit. Continuing counseling sessions have been scheduled for the couple, and Diane is "rooming in" with Paul to adjust to the 24-hour care that he requires.

Mildred's Story

by
Kathy Meyer, RN, Associate Nurse
Cathy Bly, RN, Primary Nurse

as recorded by
Boni Deckert, RN, BA

Mildred, an 81-year-old woman who developed a sudden onset of back pain and was diagnosed at her local hospital as having an aortic abdominal aneurysm (AAA), was transferred by helicopter to Lutheran Hospital-LaCrosse for further treatment. Upon her arrival, she was admitted directly to the operating room in critical condition. Following major abdominal surgery to correct the AAA, she was transferred to the 15-bed intensive care unit (ICU) with a systolic blood pressure of only 60. Surrounded by a mass of equipment, Mildred was admitted to the care of Kathy Meyer, RN, associate degree nurse.

Kathy expertly monitored Mildred's heart rate, rhythm, cardiac index, EKG patterns, blood pressure, pulmonary artery and arterial pressures, oxygen saturation levels, peripheral pulses and

extremity color, lung sounds, fluid and electrolyte balance, multiple IVs, and blood gases. She skillfully and intuitively provided the standard level of care for the ICU patient with major abdominal surgery, mechanical ventilation, and hemodynamic regulation.

With a systolic blood pressure of 60 and IV fluids already being infused, pharmacologic agents were used to raise Mildred's blood pressure. Kathy's goal was to maximize Mildred's hemodynamic stability by administering a complex regimen of medications ordered by the physicians. She carefully monitored the effects of the medications and the intravenous fluid therapy.

In response to Mildred's inability to maintain normal oxygen saturation levels, 100% oxygen was administered. Tracheal suctioning was ineffective in improving her oxygenation. Rales were heard during lung auscultation. Despite treatment, her blood pressure remained low. Pedal pulses were distinguishable only with the Doppler. Her urinary output also remained low. Mildred was placed on a Lasix drip and calcium, magnesium and potassium replacement therapy.

The following morning, Mildred was admitted to the caseload of one of the ICU's primary (BSN) nurses, Cathy Bly. Over the next day Cathy got to know Mildred and obtained her health history through Mildred's family. Mildred had three daughters: a single woman who resided in LaCrosse, a married daughter who lived in a small town about an hour's distance from the hospital, and a divorced daughter from Texas. Mildred's son Charlie lived closest to her, but had a history of surgery for a brain tumor, was emotionally labile, and presented concern to his three sisters. Mildred was the matriarch in this family. She had lived a very active, healthy life and was hospitalized only for the birth of her two youngest children. To see their mother critically ill and powerless was an overwhelming experience for the family.

Mildred had lived alone and maintained her home among a network of admiring relatives, grandchildren, great-grandchildren, and neighbors. She was partially deaf, but did not use a hearing aid; friends and family were accustomed to raising their voices to communicate with Mildred. She did her own cooking, often using the vegetables from the garden she tended. Mildred briskly walked two or three miles per day and had been raking her yard just prior to rupturing the aneurysm which caused her emergency hospital admission. She had had a good appetite, was well-nourished, slightly overweight, and experienced no problems with elimination or sleep. Religion was an important aspect of her life. Her constant companion and love of her life, however, was her pet canary!

Two days following her admission to the ICU, when she was stable enough to be weaned off of sedative pharmacologic agents, Mildred was found to have no movement in her extremities. She could appropriately respond with head movements. After several days when no improvement occurred, a neurology consult was requested. A magnetic resonance image (MRI) showed multiple old infarcted areas, encephalopathy, and a thalamic cerebral vascular accident (CVA). The Infectious Disease Service was consulted when she developed a fever. Mildred was slowly weaned from the medications used to elevate her blood pressure and the diuretics. Repeated attempts to wean her off of the ventilator were unsuccessful so a tracheostomy was performed to maintain adequate ventilation.

Kathy, the associate nurse, revised Mildred's plan of care by adding the previously established standards of care for neurological assessment, ventilator weaning, new tracheostomy, and pulmonary disease. For the average patient an anticipated length-of-stay in the ICU for major abdominal surgery is from two to three days; it was three and one-half weeks before Mildred was able to be transferred to the specialty medical unit. Post-operative dysphagia affected her nutritional status and required evaluation with swallowing studies under the guidance of a speech pathologist. Mildred's nursing care was further complicated by an extended course of parenteral nutrition and tube feedings that resulted in diarrhea This situation demanded careful skin assessment and frequent care. Throughout her hospital stay, Mildred's skin remained intact, and Kathy celebrated the success of her vigilant nursing care!

After assessing Mildred's functional health patterns, Cathy Bly, the primary nurse, instituted the first of three nursing diagnoses: impaired physical mobility. Planning ahead to Mildred's transfer from the ICU and eventual hospital discharge, Cathy wrote orders for cardiac chair positioning in order to prepare her for sitting up and to prevent episodes of orthostatic hypotension. Mildred was turned in bed according to a schedule designed by Cathy to incorporate the viewing of Mildred's favorite television shows. During these shows, Mildred was to be turned to face the television set in her room.

A second nursing diagnosis surfaced in response to the change in Mildred's nutrition and elimination patterns. Her bowel function was impaired due to her immobility and changes in her diet. By instituting a bowel program for Mildred, Cathy was able to reduce, from each time she was turned to just once or twice a day, the frequency of loose stools.

Cathy worked with the associate nurses assigned to care for Mildred and was able to communicate to them and care providers in other disciplines Mildred's individual health care

needs. Once they knew Mildred they could start to treat her like the unique person she was. Knowing Mildred allowed the staff to recognize her intrinsic worth and to view her illness as only one facet of her as an individual. Cathy expanded Mildred's repertoire of coping mechanisms and helped her expand her spiritual self by sustaining relationships with her family and by incorporating aspects of her past into her current hospital experience.

A daily routine began to surface for Kathy, the associate nurse, and the other care providers who filled in for Kathy during her off-duty shifts. Kathy liked to go on rounds with the physicians in order to give them an update on Mildred as well as to ask questions and become aware of the plan of care for the day. She communicated the family's needs and advocated both for them and the patient. Ongoing assessments were made to detect any physiologic changes. The nursing interventions developed collaboratively based on the primary nurse's nursing diagnoses and orders filled most of the day. The nursing interventions included such things as range-of-motion, positioning of extremities to prevent edema and immobility, footboard placement, the bowel program, anti-deep vein thromboembolism measures, skin and comfort care, and personal hygiene. In addition to all of the scheduled activities there was the need to allow Mildred as much control over her situation as possible; choices about her bed position, the radio, her covers, the lights, and television were given to her. Kathy also organized respiratory treatments and ventilator weaning to allow for rest periods and television time.

Initially, Kathy, the associate nurse, also responded hourly to questions from family and friends. She assisted them in communicating with Mildred. Family members initially were afraid to touch her and stood at the foot of the bed until they were encouraged to come closer. After a few days they were able to talk directly to Mildred and to touch her. When the family needed more answers than Kathy could provide, she arranged a care conference.

When Kathy first identified signs of depression in Mildred, she communicated with the primary nurse, Cathy Bly, who identified powerlessness as a problem and instituted a creative plan of care based on her knowing the "inside" of Mildred. Taped bird songs could soon be heard coming from Mildred's bedside. Images of her canary soon lifted Mildred's spirit. Cathy organized a bulletin board for pictures colored by Mildred's grandchildren and included favorite photos brought to sustain relationships with these loved ones. Scheduled rest periods provided both solitude and sleep. The "humor cart" housed movies that Mildred and Cathy watched together. "Three Men and A Little Lady" offered comedy and companionship without expecting an interactional response. The chaplain provided a presence, a touch, and a prayer. Cathy arranged for only a small cluster of nurses to care for Mildred, so they would understand her needs, leading

to less frustration from her hearing deficit and her inability to speak. She taught these nurses to capitalize on Mildred's strong neck muscles and to ask questions that could be answered with a nod or a shake of the head.

As Mildred's primary nurse, Cathy played a key role in readying both patient and the receiving unit's staff for her transfer to the specialty medical unit. Two days prior to the transfer, Cathy met with the social worker and the associate nurse who was assigned to assume the responsibility for Mildred's care. Even after her transfer to the specialty medical unit, Cathy continued to monitor Mildred's progress on a daily basis and to reassess the established plan for her nursing care.

During the hospitalization, Mildred's daughter from Texas decided to relocate to Wisconsin and to become the full-time care provider for Mildred. This would allow Mildred to be discharged from the hospital directly to her home and would eliminate the need for placement in a nursing home. Cathy organized a teaching day for the daughter that included the bowel program, use of a lift, and positioning skills. Due to intensive nursing care, Mildred was able to be discharged without the tracheostomy or tube feedings and returned to her home, where her daughter provided the necessary daily care.

APPENDIX G

DISCUSSION OF EDUCATION FOR DIFFERENTIATED PRACTICE

Margot Nelson

I am Margot Nelson. I teach at Augustana College in the baccalaureate nursing program, and I have students in the Healing Web Project who are seniors and are enrolled in a course entitled Care of Adults in Acute Care Settings. They have their clinical experience along with the associate degree nursing students from the University of South Dakota (USD) on the Pulmonary Renal Unit, directed by Cheri Dore-Paulson, at Sioux Valley Hospital. I'll let her say a few words about the unit.

Cheri Dore-Paulson

I am Cheri Paulson. I am the director of the pulmonary renal unit, which is a 30-bed unit of mostly chronically-ill pulmonary and renal patients and is primarily an elderly population. The unit provides a wonderful educational opportunity for all nursing students.

June Larson

I am June Larson. I am a faculty member at the University of South Dakota Associate Degree Nursing Program. I have first-year associate degree students on the pulmonary renal unit at Sioux Falls Hospital. These students initially come to the unit from the nursing fundamentals class with very basic skills they have learned in a lab. By the end of the first year on the unit they have progressed from having very basic care skills to comfortably caring for clients in the associate degree role.

I'd like to share with you a brief story about an experience we had with students. One day I was going to get on the elevator and go to lunch; the elevator door opened and students from USD and Augustana came tumbling out of the elevator laughing and having a good time. I said, "What's going on here?" They had to tell me a story of a lady who had gotten on the elevator with them and she noticed that there were students from Augustana and USD on the elevator, and she said, "What are you doing together? You're from USD; you're from Augie." And they said, "Well, we're in the Healing Web Project," and went on to explain to her what it is that they're doing on the unit together. And she said, "Hmph, that'll never work. I've been an educator." And off she went and they got out of the elevator laughing and thought it was the most hilarious story. For the educators in the two programs it was gratifying to hear the students' disbelief that

that kind of reaction actually happened, because we knew that in the not too distant past it was very much reality at this setting and still is a common picture in most of nursing education. We believe that the purpose of our working together was getting through to the students, and that's something that we were very pleased about.

Cheri Dore-Paulson

One of the exciting things about the Human Web Project has been the opportunity to teach students and to model the value of having differentiated roles in the provision of nursing care or health care for patients. I remember when we implemented differentiated nursing practice roles on my unit about six years ago what a struggle we had in changing the paradigm of thinking, that one nurse could be the do-all and end-all for all patients. It has taken almost six years for staff, not only nursing staff, but hospital staff as well to understand and value the different roles that nurses play in providing care to the patient. So having the opportunity to demonstrate the benefits of differentiated nursing practice to the students is one of the most positive things we've experienced with the students.

Margot Nelson

It sounds like what we're talking about is really moving nursing education in partnership with practice into a new paradigm. I think another thing that has become evident in this project has been the importance of developing the teaching role of the staff nurse. Certainly the unit director, but also the staff nurses in the primary (BSN) and the associate roles (ADN) must become teaching partners with the nursing school faculty in order to make the roles explicit. Educators know that the staff have always been seen by students as role models and as informal teachers, but we say right up front, "This is a valued part of who they are and of their professional role," and we honor that and we need that dialogue and collaboration among the staff, faculty and students.

Maybe we could go on now and talk about some of the underlying or foundational principles of the Healing Web Project and how these are modeled by the nursing faculty and administrators. This project has been an ongoing process of learning, growing, and awareness for everyone involved.

Cheri Dore-Paulson

We talk about mutual valuing of the differing nursing roles. June, Margot, and I feel that one of the most important parts of our roles is to be role models for this concept. While it sounds like something that we may put on or do as a front, this mutual valuing of each other's roles has become a very natural part of our relationship. It's hard to describe this relationship, but truly a

relationship has developed between the three of us over the course of the last three years and with that relationship has come the very natural evolution of valuing one another. We each bring very different perspectives to the project and we each have very different philosophies and values about things. It's having and being aware of this diversity that has enriched the learning opportunity for these students.

June Larson

The mutual valuing that we all have for each other is something that we talk about with students, and how important it is that they value each other and understand that each of them has a very important role in the whole of nursing. Students and programs are different, but one is valued as equal as the other and no one is more important or less important to the delivery of health care because of the educational process they have chosen. The students are also taught that they have a different educational role or different role in nursing practice because of the educational foundation that they are acquiring through their nursing program. This concept, played out in many different ways and experiences, has been an important part of what we as the faculty do. Cheri and her staff nurses talk about differentiated practice and teach clinical topics in the students' learning seminars. This joint teaching demonstrates, I think, that the staff are equal partners in this project with the faculty. It also stresses that this project belongs to all of us and that none of us could do it alone. Just as the faculty and staff need each other, nursing needs all roles within nursing in order to provide the whole of nursing care. This is a concept that we work on with the students on a day-to-day basis.

Cheri Dore-Paulson

One of the other concepts that we play out on a daily basis for the students is communication. During the course of four years we have had a great many opportunities to communicate on issues and conflicts that have needed to be resolved. Again, if we as faculty cannot role model communication and conflict resolution, how can we educate the students to do that?

The credo that the Healing Web Project operates by, modeled after the Native American counsel process, "Speak honestly, be brief and listen from the heart," comes to mind. We have had the opportunity to exercise this belief many times over the last four years in this process. But it has been through some of the thorniest times that we have been able to communicate with one another and have come through with a positive outcome and a better opportunity for growth for ourselves and for our students as well.

Margot Nelson

Another important concept underlying this interweaving of education and practice has been helping students deal with ambiguity. We as faculty have had to model how to deal with that ambiguity. As June explained initially, the USD students enter this clinical experience in the fall as first-year students with only very basic skills, and the Augustana students enter the project as seniors. As the USD students move more fully into the associate degree role and the Augustana students move into the baccalaureate degree nursing role each time they come to a clinical session we are in a process of renegotiating who's on first or who's doing what. This negotiation is between the students, between the faculty, and with the staff, so it creates an ambiguous situation; but it is working. It is helpful for the students to see that one can negotiate and survive in this ambiguous or evolving environment. It is also a good mechanism to promote creativity and innovation. Things are not as prescribed as we have often been comfortable with in nursing education; situations are not spelled out in detail and need to be recreated every time.

Cheri Dore-Paulson

I think right on the heels of ambiguity comes the issue of change. In an ambiguous world it is necessary to change frequently; we receive evaluations from our students, and we ask for feedback. The faculty and staff try to remodel and reshape the program based on the feedback that is received. For this reason we have made some major changes in the program very quickly based on the feedback that we have gotten. Again, I think in doing that, we are also modeling for the students that we can make change; we can adapt to change. It betters the product and provides growth opportunities for all of us.

June Larson

Perhaps it would be beneficial at this point to review some of the major concepts of the Healing Web Project. These concepts are mutual valuing, communication, collaboration, collegiality and developing a true partnership. Developing a partnership is something that we are working on within both of the schools of nursing and are now beginning to reach out to medicine and work with the school of medicine. The medical students take part in the patient care seminars on the clinical unit with our nursing students to give all of the students while they are still in the student role an opportunity to communicate and talk to each other about patient situations.

The two nursing faculties and the nursing administration are also looking at interdisciplinary care and the need for nurses and all health care workers to learn to communicate and collaborate process in the care of the patient. Nursing students have participated in grand rounds, which are very much interdisciplinary, and which provide them an opportunity to learn the collaborative and

to be thinking about the kinds of things they as health care providers can add to the total patient care picture.

Cheri Dore-Paulson

Before we started this dialogue we talked about the importance of building the right team. I feel that the right mix of people is really important to embark on a program such as the Healing Web Project on differentiated nursing practice. June, Margot, and I come from very diverse backgrounds and our personality types are somewhat different, but that diversity is really what adds the value to the team and keeps us from getting too routine and humdrum. We're able to look at all of the possibilities based on our different experiences and perspectives.

Margot Nelson

I would describe this whole process for our two faculties and for Cheri's staff on the pulmonary renal unit as an evolving one. At one point we borrowed an idea of Jean Watson's, which is that of throwing the road out ahead, which is the aborigine's way of doing things rather than just following the paved roads. I think that mindset really gives one an opportunity to evolve something more exciting than merely following.

We were also discussing among ourselves whether we did this project backwards in that we didn't start concretely from our two curricula and from the philosophy at Sioux Valley, although those were underlying everything that the group did. Rather we came together with this mutual idea of doing something worthwhile to address some mutual needs that we saw in education and practice. And, now, we are in the process of going back the other way and going to do further evaluation of our curricula to see if that reflects what we've done together.

June Larson

And the interesting thing about that is, with nursing being in such a state of change we are all changing our curricula; and I know for USD many of the concepts that are so essential to the Healing Web Project are also major concepts in our School's philosophy. I guess that addresses what Margot said; we started with the ideas and went ahead with them, and now we are looking back at our curricula and saying , "Yes, that is important to us curriculum-wide." We didn't feel that every part of the curriculum had to be in place first. And I think that's an important part of this process; to allow yourselves to be creative and open to change and open to trying some new things.

APPENDIX H

DIFFERENTIATED PRACTICE: A FISCAL CASE STUDY

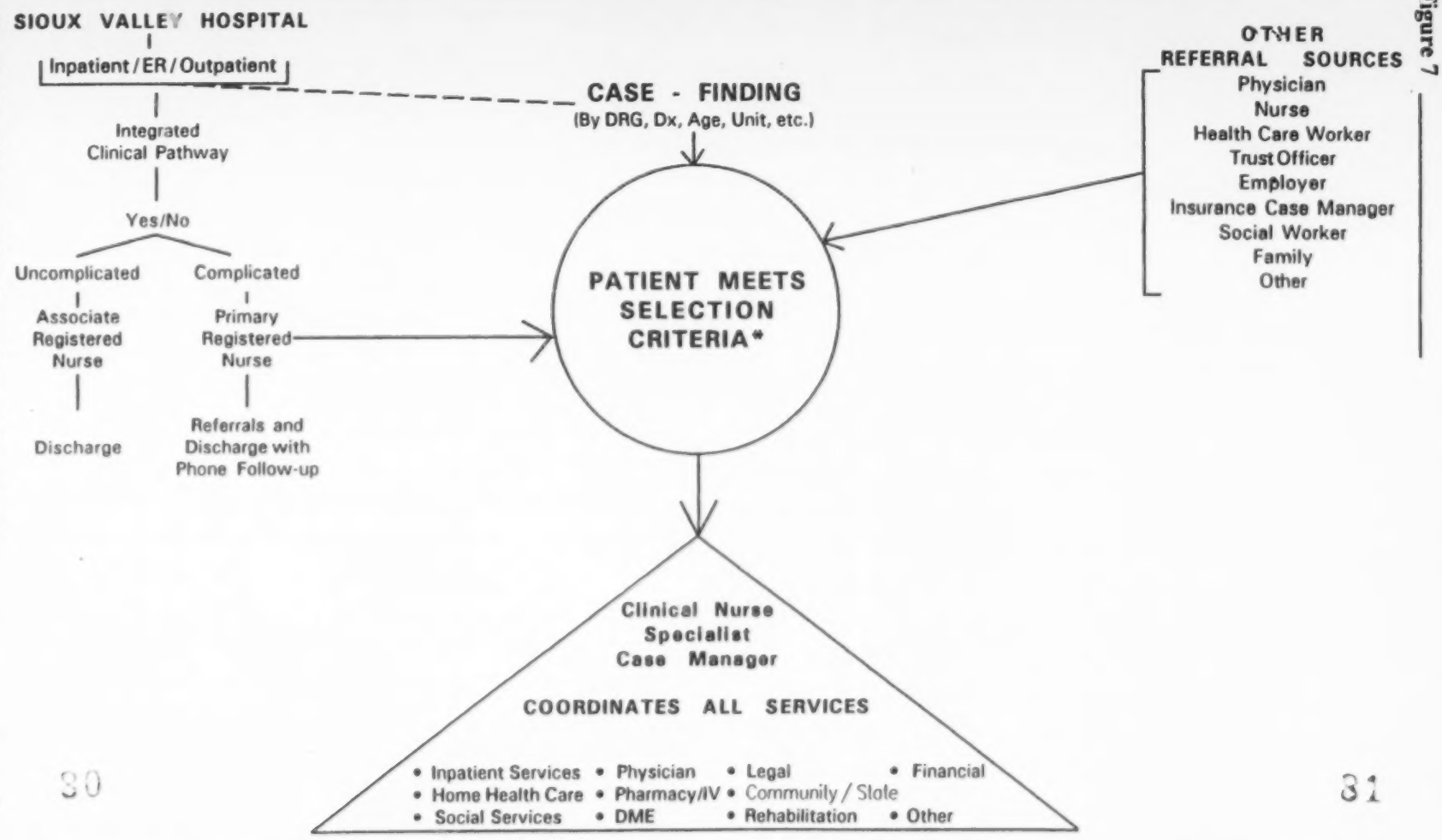
Sioux Valley Hospital (SVH), a 420 bed tertiary care hospital and the largest in South Dakota (SD) implemented differentiated nursing practice, shared governance and case management in an extensive six-year process of care delivery redesign. Further, it expanded the model into patient focused care, while adding a strong program of continuous quality improvement. The fiscal impact of this restructuring effort has been impressive.

To put this model into action, the hospital divided the nursing staff into three groups while eliminating most centralized nursing roles (discharge planners, clinicians, and supervisors). Seventy percent of the nursing staff functions in the associate role (AN), based on associate degree nursing (ADN) competencies, and is working at the bedside in a traditional registered nurse (RN) role. They work from an "integrated clinical pathway" and are the sole nursing provider unless the patient demonstrates complexity which requires interventions beyond those identified on the "Integrated Clinical Pathway." The second group functions in the role of primary nurse (PN), based on baccalaureate degree nursing (BSN) competencies and role expectations, and are responsible for complex patients from pre-admission to post-discharge. This group is responsible for integrating medical and nursing orders for patients that "extend beyond" the identified pathway. They are accountable for a timely, well-prepared discharge, and on occasion will follow a complex patient into the home to provide home health care beyond the services typically offered by the home health agency. Clinical nurse specialists (CNS) or nurse practitioners (NP) who hold advanced degrees comprise the third group of nurses, advanced practice nurses (APN), at SVH. They provide case management across the healthcare continuum in all settings and across the client's lifetime, caring for chronic or complex clients needing advanced care interventions and support (Figure 7).

An "Integrated Clinical Pathway" is defined as a tool to manage a patient's care through an acute episode of illness. Clinical pathways map or outline care on a timeline and are specific to a medical diagnosis or surgical procedure and to a physician group. Certain categories of care are highlighted, e.g. tests, treatments, consults, medications, activities, nursing interventions, patient teaching, and patient outcomes. Key activities that need to occur in a predictable and timely manner to achieve an appropriate length of stay with expected patient outcomes are also listed. An interdisciplinary approach is used, and resources are coordinated by the associate nurse,

Figure 7

Sioux Valley Hospital Center for Case Management Conceptual Framework



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*** Guidelines for Patient Selection**

1. Chronic illness or catastrophic event, i.e., high risk pregnancy
2. History of frequent admissions or utilization of emergency services
3. Fixed financial resources / reimbursement
4. Inadequate caregiver support / lives alone
5. Cognitive / developmental deficit
6. Emotional support needs / coping deficit

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primary nurse, and advanced practice nurse to achieve high-quality care in a cost-effective manner (Koerner & Karpiuk, 1994, p.162).

Analysis of patient populations (Figure 8) reveals that approximately 60% of all patients have few complications during their hospital stay, and will receive care from the associate nurse alone. Primary nurses work with patients needing more intensive, uniquely tailored care to experience a timely and safe discharge. Approximately 30% of the patient population demonstrates this degree of complexity. A third group of patients are very complex, often chronically or terminally ill, demonstrating a frequent re-admission pattern to multiple health care providers. This complex patient population, approximately 10% of all admissions, is cared for by the advanced practice nurse. In this analysis, the patient mix did vary between the critical care and medical-surgical care areas of the hospital.

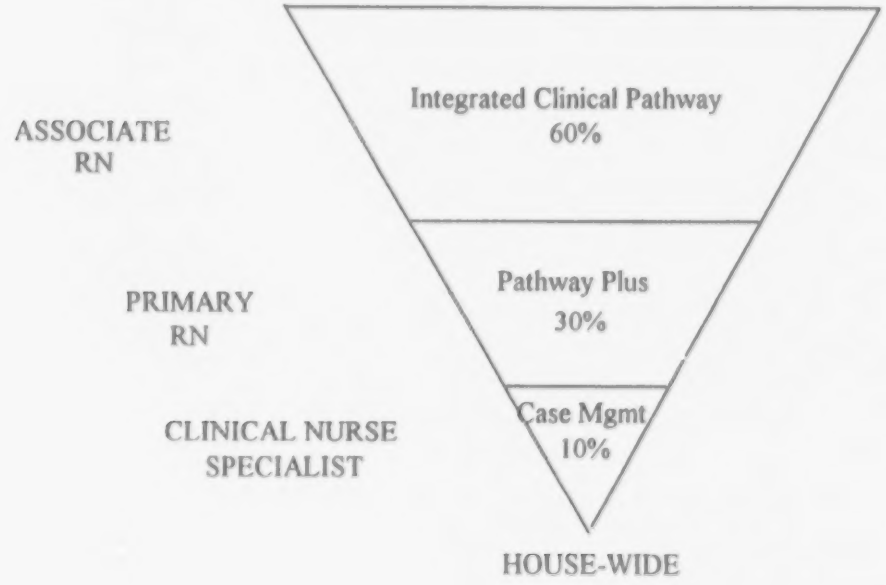
Cost saving efforts were first initiated in 1991-1992 through development of "Integrated Clinical Pathways". The process began with the identification of the highest volume/highest loss diagnostic related groups (DRGs). The nursing staff identified cardiology as one area that should be addressed. They also noted the practice patterns of Dr. R, a model medical practitioner. Before introducing "pathway management" Dr. R.'s average patient stay was a full day shorter than his colleagues' patients. After the model was implemented using Dr. R's patients, the difference in length of stay increased; his colleague's patients stayed, on an average, four days longer than his patients (13.7 compared to 9.4 days).

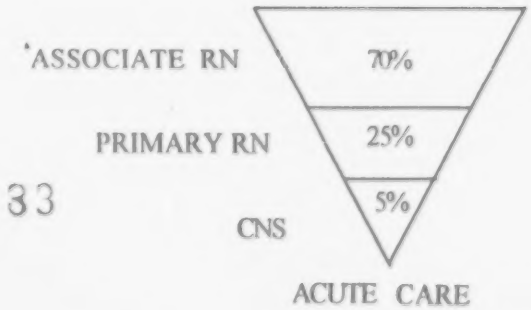
By successfully shortening patients' length of stay, pathways management also reduced patient care costs for Dr. R's patients by more than 22% (from $45,00 to $35,000). The nursing staff noted that, following the critical event of surgery, the patients were not being discharged as quickly as they could be because certain medical follow-up procedures such as the advancement of lines were not being completed because of competing demands for medical attention by more acutely ill, newly admitted patients. An APN, therefore, was brought in to assist with the peri-operative process. This APN met with the Primary Nurses to identify factors that were holding patients in the post-operative phase. The APN then worked with Dr. R. to help streamline the post-operative period for his group of patients. Adjustments in the pathway and nurse/physician practice patterns reduced the average patient's costs by another $1445, an aggregate savings on this product line of $1.6 million/year.

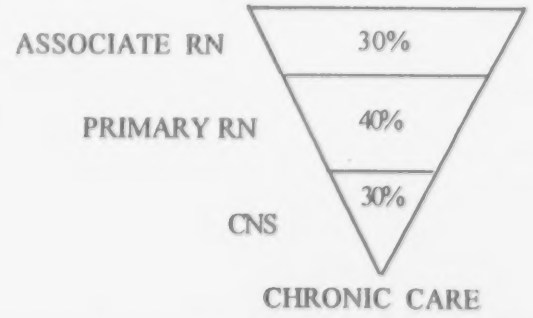
At approximately this same time, the Health Care Finance Administration (HCFA) published a listing of the 15 hospitals in the U.S. with the lowest 3-year mortality rate; SVH was listed as one

Figure 8

CASE MANAGEMENT THROUGH DIFFERENTIATED PRACTICE
PROJECTED PATIENT PERCENTAGES







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of these hospitals. Further, Lexecon Health services published a study in *Modern Healthcare* (November 30, 1992) identifying the nine "superproviders" for coronary bypass procedures. Sioux Valley Hospital (SVH) was again one of the nine organizations noted for the highest quality and lowest cost for this procedure: the one procedure or category of patient that had been addressed in the "pathway" project.

As multiple pathways were developed for various physician practice groups, a pattern became clear. Too many patients with highly complex care needs were not being discharged from the hospital in a timely fashion. A case management project was designed to assist 35 complex patients for a six-month period. Results during this test period for these 35 complex patients included:

* Total number of admissions for the group decreased by 27%, from 51 to 37 admissions;
* Length of stay decreased by 66%, from an average of 35.5 days to 12 days;
* Number of inpatient days dropped by 66%, from 1,247 days to 423 days;
* Number of days in the intensive care unit dropped by 96% from 257 days to 10 days; and
* Cost savings from providing care on an as-needed basis totaled $552,666.

The guiding principle used for the continued refinement of this care delivery model was to place the highest quality/lowest cost provider next to the patient, based on the patient's need at that particular stage of his or her illness event. Examining SVH's Medicare "book for business" for the past two years also revealed the following changes:

SVH DRG VARIANCE REPORT

FY	Case Count	Average Reimbursement	Average Cost	Average Variance	Total Variance
1992	7,056	$6,375	$7,666	-$1,291	-$9,108,541
1994	7,098	$6,966	$7,600	-$633	-$4,498,066

SVH was identified as one of the "100 Top U.S. Hospitals-Benchmarks for Success" in a study conducted by HCIA and Mercer in January, 1994, (*Modern Healthcare*, January 17, 1994). Sioux Valley Hospital was again given this distinction in the repeat study conducted in November 1994 and to be published in *Modern Healthcare*, November 14, 1995. These studies identify the nation's best performing general acute care hospitals on the basis of objective criteria from aggregate annual Medicare cost report and discharge data. To qualify, hospitals had to rank above

their peers on eight measures of effectiveness and efficiency in clinical practice, operations and financial management. If all U.S. hospitals would perform at benchmark levels the results, it is estimated, to the health care industry would be significant:

* Expenses would decline by $21 billion;
* Average length of stay would drop by more than a day;
* Mortality rates would drop by 17% and complication rates by 14%; and
* Hospital charges would decline by $43 billion.

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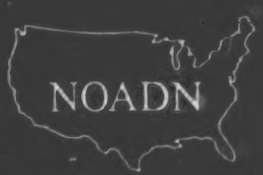

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